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# DICAL CHAOS AND CRIME

NORMAN BARNESBY, M.D.

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MEDICAL CHAOS AND CRIME

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# Medical Chaos and Crime

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# MEDICAL CHAOS
# AND CRIME

## by Norman Barnesby, M.D.

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# PREFATORY CHAPTER

THIS book is mainly an exposure of the abuses that exist in the medical profession in this country, abuses that not only degrade the practice of medicine, but contribute not a little to the physical and moral deterioration of the American people. It would be futile to attempt to estimate the amount of human suffering caused by the ignorance, incompetence, commercialism, and criminal indifference of those who call themselves disciples of Æsculapius, but the evil may at least be pointed out and denounced, and this I have done. I presume that the result will be accounted sensational, although I have scrupulously striven to avoid any exaggeration, and have endeavored to present both sides of every question discussed.

I have dealt rather briefly with what is known to the general public as medicine proper, that is, internal medicine, while surgery, gynecology and obstetrics occupy eight chapters, and repeatedly recur in nearly every other chapter in the book. This was not my original intention, but it happened that the surgical chapters were written first, and so overran the space I had allotted to drugs. I hope that time and circumstances will permit the preparation of a supplementary volume. I should, perhaps, have made room for one more chapter showing wherein the public are at fault, but this has already furnished a text for innumerable eulogiums of the medical profession as it exists, and so I deemed it unnecessary to attempt a dual rôle.

It would be idle to deny that in addressing these disclosures to lay readers there is the possible danger of causing one of those periodic iconoclasms which, under certain psychological conditions, might end in a popular stampede into foolish and pernicious fads. This would not only be unfortunate for the laity, but might also bring temporary hardship to an honorable minority of the profession who have continued to hold to their ideals, and deserve only the highest praise and encouragement for their patient self-sacrifice in serving a public not too intelligent or grateful.

Nevertheless, I cannot conceive of any hysterical outburst or frenzied legislation that could outweigh the good that must result from a plain recital of the monstrous abuses that have become entrenched in the profession of medicine and surgery, especially in the cities. As to the propriety of letting the public into professional secrets, I have little to say. Too many lives have already been sacrificed upon the altar of medical pretension and sham, and if I knew that this volume would result in the saving of but one human life, and on the other hand the utter demolition of the entire "ethical" edifice, I should issue the book, save that one life, and call the price a bagatelle.

I am aware that my motives will be misconstrued, my statements challenged or misrepresented, and the reform measures suggested in the final chapter subjected to the most hostile criticism. This is the unavoidable experience of the reformer, and I must brave the storm as best I may.

But I am in goodly company. Hundreds of the best men in the profession have denounced these abuses in the most scathing terms, and thousands of honorable, albeit timid, physicians have endorsed their utterances in private. The medical journals, moreover, almost without exception and to their great credit, have become increasingly outspoken on these matters, and medical conventions are frequently given over to some phase of the ever-recurring question: How shall we purify and elevate the profession?

This, of course, is an excellent indication; indeed, were it not for such signs of awakening moral vigor, the outlook would be far from hopeful. But mere agitation in itself is not necessarily reformative, and indignant diatribes uttered in a whisper are likely to be much less effective than a strong voice that shall tell the whole truth to the whole nation. In short, the time for half-way measures and professional secretiveness has gone. The danger is urgent: clear speaking and the widest publicity are essential.

I think the late Grover Cleveland had an inkling of the real conditions which prevail when, in an address to the Medical Society of the State of New York shortly before his death, he urged the profession to abandon their outworn policy of mystery and infallibility and treat the public with more frankness and consideration. " We have come to think ourselves as worthy of confidence in the treatment of our ailments," he remarked, " and we believe that if this is accorded to us in greater measure, it would be better for the treatment and better for us. We do not claim that we should be called in consultation in all our illnesses, but would be glad to have a little more explanation of the things done for us." And again: " It should not be considered strange if thousands among us, influenced by a sentiment just now astonishingly prevalent, should allow ourselves to be disturbed by the spectre of a medical trust in mystery, and like all who are truly affrighted should cry out for greater publicity between physician and patient."

How well-founded these vague but intuitive fears were, Mr. Cleveland probably never knew, and neither will the general laity until the searchlight of publicity has been turned into the darkest corners of this modern chamber of horrors.

"If the mighty host," says Dr. George W. Wagoner,[1] "of those who have been rushed into untimely graves by incompetent, pretending physicians could be marshalled into an army and marched in ghastly review before the astonished eyes of our indifferent legislators, what a ghost-like multitude of outraged victims there would be! one which would appal by its magnitude and horror, and excite the law-makers to a frenzy of action in the elimination of the incompetents from the ranks of those who assume to care for our health and lives."

I doubt if the author or artist lives who would dare attempt such a repulsive work of realism as Doctor Wagoner imagines, and I agree with him that it would be entirely too provocative of the mob spirit; but the main facts we do want and must have, if we are to rid society of this festering sore; and these and these only it has been my earnest endeavor to collect and present to those whom they may concern—the victimized public.

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[1] "Doctors and the Public." The President's address delivered at the general meeting of the Medical Society of the State of Pennsylvania, Philadelphia Session, September 28, 1909. Published in the *New England Medical Monthly,* December, 1909.

I offer no excuse for the copious quotations that I have given, and if certain chapters seem but compilations, it is better to have them so if the reader is thereby helped to a clearer understanding of the situation, than that any attempt should have been made at mere rhetorical effect.

I do, perhaps, owe an apology to the authorities quoted, for I am perfectly aware that I am sounding upon the housetop things that if not told in secret were certainly intended only for medical circles; but, on the other hand, I owe it to myself to add that several prominent doctors whom I took into my confidence expressed their pleasure at the prospect of a public exposure of these evils, so long as they were not directly implicated. The chapter on "medical ethics" will explain this apparent faint-heartedness, and show how a system almost mediæval in its spirit is largely responsible for their lack of initiative and for a cautiousness that only too frequently merges into rank cowardice.

While I have quoted from many of the leading authorities in the several branches of medicine, such as Doctors Osler, Jacobi, Holt, Price, Lusk, the late Doctor Senn, Doctor Eliot, President Emeritus of Harvard, and others, men of international reputation, whose utterances receive the respectful attention of the profession throughout the world, I have not hesitated to add largely from the testimony of less famous men where their investigations and opinions deserve a hearing, nor have I confined myself to doctors exclusively of one school.

The bulk of these extracts has been taken from addresses given before medical or other scientific societies, and from articles contributed to medical reviews; and here a few words of explanation are required. It will be noted that I have ignored text books as far as possible, on account of their technical language and because I have usually been able to find some monograph by the same author which gives his views in condensed and more readable form. I have, moreover, quoted largely from addresses to students and medical bodies because of the broad perspective usually found in papers of this nature, as well as the fact, if I must confess it, that here, if anywhere, we are apt to catch the author off his guard and so come to his real convictions and viewpoint.

As to the source of such addresses, most of which have been published in one or more periodicals, I have simply made use of any reputable journal that reproduced the author's paper verbatim, and have given credit accordingly; but the reader should bear in mind that the papers which I have quoted will be found in the transactions of the particular society before whom the address was delivered, and frequently in half a dozen or more medical journals as well. This, of course, will permit of a speedy verification of any passage in the slightest dispute.

It may be objected that I have exhausted the pages of contemporary literature in order to bolster up a "case" against the profession, and hence, by an unfair selection and by over-emphasis, have created a false or contorted impression of the principles and present practice of medicine. This is not so. Of the material that I have collected from periodicals, I have been able to quote from perhaps a tenth of the articles supporting one or more of the charges I have made, and it is safe to say that I have not examined a fifth of the current medical literature of the last decade. A perusal of the appendix, furthermore, wherein will be found a few of these articles, nearly or quite in full, will show that in some cases, at least, the briefer extracts in the body of the book have understated rather than overstated the position of the author quoted.

Those whose cases are cited as examples of the abuses I have set forth are dealt with leniently, their identity being hidden under fictitious initials and in some cases under a fictitious place of residence. For I see neither reason nor justice in stirring up personal animosities by exposing a few culprits when thousands (not hundreds) of the profession are equally guilty. Nor do I wish to give sorrow to the bereaved friends of the many victims I have dragged forth, as it were, from their long sleep to serve in this very public, and necessarily spectacular, clinic.

In short, I am attacking a system, a social condition, for which we are all partly responsible,—doctors and laity, scientists and charlatans, law-makers and law-breakers. And particularly do I wish to emphasize and stigmatize the spirit of false ethics and infallibility that the medical profession alone has succeeded in preserving intact, a memorial of the myths and inhuman practices of our mediæval prototypes. What one man, I repeat, could estimate or depict the awful harvest of suffering and blood that we as a nation are reaping from our criminal apathy in allowing an organization of men as fallible as those of any other profession to acquire an irresponsible power of life and death over millions of helpless human beings?

However, while I could not present the whole of the evidence if I would, nor would I if I could, I have undertaken my difficult task with the determination to prove enough to justify this appeal to the laity. For I am persuaded that the remedy lies in a full enquiry, nation-wide in its scope, the abolition of all codes and practices inimical to society, and a complete reorganization of the system on the lines of legislative supervision or other responsible control. Thus, and thus only, can an erstwhile noble profession be purged of its corruption and the public adequately served and safeguarded.

# MEDICAL CHAOS AND CRIME

## CHAPTER I

### THE REIGN OF "GRAFT"

"Always seek your own interests, make of a high and sacred calling a sordid business, regard your fellow-creatures as so many tools of trade, and if your heart's desire is for riches, they may be yours; but you will have bartered away the birthright of a noble heritage, traduced the physician's well-deserved title of the Friend of Man, and falsified the best traditions of an ancient and honorable Guild."—Dr. William Osler, in "Æquanimitas and Other Addresses."

One would think that those who are especially fitted by training and education to treat the sick and injured, and to relieve suffering, would have developed in them to a high degree the divine qualities of sympathy and compassion. Unfortunately our ideals and practices have undergone marked changes of late, and the medical profession has by no means escaped the mercenary blight that has fastened itself upon the nation. To be absolutely fair, I will except the rank and file who are removed from the larger cities, though urban greed and

" graft " is fast spreading to the remotest hamlet. But I fearlessly assert that the leading surgeons and practitioners of the cities are no longer the men of exalted aims and scrupulous honor that formerly ennobled our profession. A valiant minority, true disciples of Æsculapius, are employing the wonderful agents that modern science has given us to true humanitarian ends, but to the majority they have become but the instruments of self-aggrandizement.

In all our great business centres the main idea in nearly every trade and profession is to make money—big money—not after the honest and leisurely manner of our fathers, but in the frantic, get-rich-quick fashion of the Twentieth Century. It is in the air, this mad desire for unearned riches, and its baneful influence is already sapping the vitality of the nation. Even now the handwriting is on the wall, though unnoticed and unread by the frenzied mob who are struggling to reach the goal of wealth. I refer to the appalling increase of crime, insanity and suicide during the last decade. If our people do not pause in this wild career we shall soon—I mean we of the cities—become a race of neurasthenics and degenerates. And the members of the medico-surgical profession are no exception. It is no longer the call of the suffering that inspires them, but the call of the dollar. They who should by precept and example strive to bring the nation to its senses are themselves in the thick of the scramble. Ethics have been undermined, principles pigeon-holed, ideals suppressed or reduced to a business basis.

The average doctor, in short, hasn't time to think of the real things of life. He knows theoretically, just as every intelligent man knows, that wealth, instead of promoting peace of mind, in nine cases out of ten undermines all happiness. The possession of ten thousand dollars leads to the desire for a hundred thousand, and a hundred thousand immediately suggests a million. Or perhaps the ownership of a store or factory creates an obsession for monopoly, and so the game must be played to the limit no matter what ideals have to be sacrificed. Thus with such over-ambitious natures, each added possession but adds to his voracity; realization brings only a new discontent, and again he sets out after a transformed and yet more elusive will-o'-the-wisp.

There is a tremendous satisfaction in life if we could only keep the fact before us, in performing well each duty that presents itself. It may be a remarkable feat (of courage or skill or cunning or what not) to make a million dollars, but there is less honest satisfaction in it than that which comes from the saving of one life. Yet so false have become our standards that many a physician, formerly honest and even altruistic, has come to look upon the relief of suffering or the saving of a life as merely incidental to the earning of a fat fee. And from honest greed, if there is such a thing, the step is but a short one to dishonorable practices and deceit. Like all who have lapsed into rank commercialism, he finds that he must employ unfair means if he would achieve the success that he craves.

What a pity that we are losing those great-hearted physicians of the old school—the Doctor McClure type as depicted by Ian Maclaren! But the spirit of the age will not tolerate them. Success, no longer a gauge of character, must be measured in dollars!

"It is not too much to say," writes Dr. C. W. Lillie (of East St. Louis),[1] "that more is expected of the doctor, and in the final accounting more will be required of him, because of his superior knowledge. It is also true that many doctors are so engrossed in money-making schemes, with fads and specialties in medicine, with fast horses, with automobiles, with women, wine and other dissipations, that patients have but slight consideration; that efforts directed toward the general betterment of mankind have but a small share of their attention."

Doctor Lillie hastens to add that he absolves the large majority of doctors from such a sweeping charge, but so do many others who write in a similar vein, and their denunciation sounds so frank and spontaneous and the added qualifications usually so stereotyped and perfunctory that one wonders if the man has not spoken only to be suppressed by the cautious physician or scientist. In some cases the former comes off victorious, but in still others the paper or address is the interesting record of an evenly matched contest between the two, honors to be decided by the tone of the final paragraph!

Such, in a measure, is the address of Dr. L. Emmett Holt, Professor of Diseases of Children in the New York College of Physicians and Surgeons (Columbia University), which he delivered before the students on September 26, 1907.[2] In the following paragraph, for instance, the professional man has the upper hand:—

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[1] From "Duties and Obligations Relating to Tuberculosis." —The *Illinois Medical Journal,* January 19, 1907.

[2] Professor Holt's paper was entitled "Medical Tendencies and Ideals," and was reproduced in the *Journal of the American Medical Association,* March 9, 1907.

"Two years ago I was in attendance with another physician on the young child of a wealthy merchant, who was seriously ill and over whom was hanging the possible necessity of a grave surgical operation. The parents were naturally very anxious. When, after one of our consultations, the surgeon had left the house, the father said, 'Do you think that man's judgment in deciding to operate would be influenced by the fee he would receive for it?' Happily, in this instance, I could say, 'Emphatically, no.' Nor do I believe there are many men in the profession of whom it would be true. But this anxious parent expressed a distrust which many others have felt. Conceive, if you can, a condition of society in which such a feeling of suspicion should be general, or worse still, when it should be justified. What technical skill can ever take the place of moral character in a physician or surgeon? High ethical standards have been maintained in the past by the great body of physicians to a remarkable degree, often in the face of great temptation. Let us hope that the ideals of the physicians of the future may be just as high."

Then the man speaks out:—

"There is one other phase of commercialism seen in our day, which may be characterized as medical graft. This man does not conceal the fact that he is in medicine for what he can get out of it. With respect to every transaction he adopts the politician's anxious query, 'Where do I come in?' His methods are well known. He visits the specialist, the surgeon, or consultant, ostensibly in behalf of his patient, and lets it be known that he expects 'the usual percentage' of the fee in case the patient can be persuaded, intimating at the same time that if this is made satisfactory he will need consultations in the case of other patients, and has other work which he can turn over to the surgeon."

Now the professional man once more:—

"Medical grafters of this type, I am glad to say, are not numerous, but they are, I must believe from my information, increasing rather rapidly. Such a man may not be at heart dishonest. Let us try to follow his mode of reasoning. He begins by contrasting his own small fees and modest income with those currently reported of the specialist or surgeon. 'Why should I not receive a suitable commission for the business I can control? There are plenty of skilful men who are willing to divide their fee with me. The patient is well served. Who, then, can complain?'"

Whereupon the man, waxing indignant, interrupts:—

"Such a man belongs in business, not in a profession. He regards the patient as something in which he has personal or property rights, as a marketable commodity, which he is at liberty to dispose of to his own advantage."

And so on throughout the Doctor's most instructive address.

As stated above, however, I will confine myself for the moment to city practitioners and surgeons, and endeavor to show to what degree they have been affected by the reign of "graft." But the sad recital will not end with this chapter; underlying many, perhaps the major portion, of the abuses exposed in the succeeding chapters will be found this insatiable mania for unearned wealth, unearned honors, undeserved reward.

Of course, it is absurd to assume, as so many do, that ideal conditions once obtained universally in this or any other profession. Just by accident the other day, I ran across a "dissertation" by Dr. Worthington Hooker which was read before the annual meeting of the Connecticut Medical Society, May 8, 1844. Doctor Hooker's theme was "The Respect Due to the Medical Profession and the Reasons that it is Not Awarded by the Community." It is a "muck-raking" article, in its way, and contains some very plain language. On page 16, we read:—

> "The science of patient-getting is often more assiduously studied than that of patient-curing. Real success is not so much desired as the mere appearance of it. Common ground is taken with the charlatan. The people are to be imbued with a great sense of the physician's skill without any reference to real merit. The object is to be attained at any rate, and whether it can be done on true or false grounds seems not to be material."

Nor are we to suppose that England or the Continent is free from these evils. It is only a few years since the death of Roose, one of the greatest charlatans who ever plied his trade; and not a few of England's best-known practitioners will go down in history as clever "grafters." But this book deals with conditions to-day, and in our own country, and references to the past and to foreign countries will be made for comparison only.

No doubt there are thousands of struggling doctors who, if they could be prevailed upon to tell the truth, would admit the deceits and petty frauds that they practise on their patients, but would plead pecuniary embarrassment or downright poverty as an excuse. In the summer months, for instance, an ordinarily good practice often dwindles down to almost nothing, yet the rent and living expenses go on just the same. The worried doctor, with wits sharpened and conscience dulled, looks about him for relief, and then it is that the unwary patient is advised to undergo an operation or receives a long course of treatment.

"The tonsils must come out!" A familiar remark, is it not? Furthermore, it is much better to operate in June or July (if you can hold your patient) than in the winter or early spring when business is brisk. "Yes, Madam, the warm weather is the time to operate on the tonsils—wounds heal more rapidly in the summer time." Poor mothers, they are so easy to convince and so anxious to do the best for their little ones!

What a cowardly and contemptible business this is when we look into it—to deceive the loving parents and ignore the needs of the children just to relieve a depleted pocketbook! Yet it is constantly being done. Who ever hears such advice in the free clinics? There the present is always the time to operate, and sorry would be the plight of the children of the poor if only summer operations were successful. But with the private patients it pays to delay, and, furthermore, it adds to one's reputation. For paradoxical as it may seem, the patient who is faked is the patient who is grateful. The modern practitioner's chief asset, in short, is not his knowledge of medicine, but his ability to convince people. Whether right or wrong, if he can impress his patients he may feel sure of success, but if he cannot he might as well throw up his practice.

Inability to read the patient's thoughts, moreover, makes a poor outlook, whereas a thorough and intuitive grasp of their methods of reasoning almost invariably presages success. In a word, to coincide with your patients' ideas, whether right or wrong, is highly politic, and to oppose them in nine cases out of ten means simple disaster.

A well-known physician, an acquaintance of mine, practising in New York City, whose reputation is of the best, told me recently that his great success in medicine was not due to any unusual skill or knowledge, but to the fact that he was " a damned good business man and knew when to take advantage of the other fellow's ignorance." After further investigation of my friend and his methods, I discovered that he was rated so highly simply because he could cure the ills he personally caused. For a patient to consult him and get away without having to return is almost unheard of. His first diagnosis when he finds that the patient is a drivelling hypochondriac is " stomach trouble," " gastric catarrh," " gastralgia," or some other reverberating name, which means nothing in particular, but greatly impresses the patient. His first treatment in such a case, almost without exception, is to administer to this poor creature large and repeated doses of potassium iodide in some form, with instructions to return if he feels nausea, headache, pain, or a bad taste in the mouth.

Now it happens that potassium iodide, given in large and repeated doses and taken with a small quantity of water, causes these exact symptoms, viz., nausea, headache, pain in the stomach and a bad-tasting mouth. Consequently the dupe goes back for relief, financial and otherwise, and so the iodide is gradually reduced, while the pocketbook is being relieved of its contents. In the course of the second or third week the poor, frail, shadow of a patient wanders into the office once more. My friend now takes pity upon him by withdrawing all of the iodide, thus effecting a brilliant cure of the disease with the high-sounding name. The delighted patient, naturally, is most grateful. Having other friends afflicted with stomach trouble, he tells them of the clever doctor who has dragged him from the jaws of death. They, too, flock to the master physician, and of course are eventually " cured," the time in each case depending on the limit of patience and the extent of the bank account.

This is a case of vulgar, though highly systematized, fraud. The following, related by Dr. W. F. Manton (of Detroit)[1] illustrates the callous indifference shown to the poor:—

" A patient, pregnant about the fifth month, was brought into one of our hospitals in a moribund condition. She was young and vigorous, and, save some slight bladder irritation, had been well up till the morning of the day when convulsions set in. Dilation of the os had begun, and at the hospital evacuation of the uterus was readily accomplished. The patient did not, however, regain consciousness, and died a few hours later, in spite of the most energetic efforts to save her life. The urine of the patient had not been examined prior to her entrance at the hospital, and in conversation with her physician the remark was made that it still appeared necessary for the general practitioner to learn that the urine should be tested from the beginning of pregnancy, to which the doctor replied, 'Doctor, it does not pay.'

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[1] From "The Relation of the Physician to His Pregnant Patient."—The *Canadian Practitioner and Review,* December, 1906.

"The case is a pathetic illustration of the present status of obstetric practice. Here was a young woman of the poorer class, in robust health, whose life was sacrificed on account of her inability to adequately reimburse the physician for the time and skill which he might expend in caring for and directing her during the period of gestation. Unfortunately the case is not exceptional, nor is the physician to be held wholly blameworthy for following a course which is almost universally practised among patients in all stations of life."

The next case, related to me by Doctor H. of New York, illustrates the shameless greed too often associated with deathbed consultations. "I went into a small cigar store, the other day," remarked H., "and was roundly abused by the proprietor when he found I was a doctor. I asked him what he meant, and he told me that his wife had recently died, and that the family doctor had insisted on calling in six specialists for consultation.

"'He called those men in,' said the poor fellow, 'and all the money I had in the world was eleven hundred dollars. The first demanded three hundred dollars, and the rest of them got the balance. They were called in and paid within twenty-four hours, and at the end of that time my wife was dead and I was obliged to borrow money to bury her.'"

This seems almost incredible, but Doctor H. made enquiries and found the man's story to be substantially correct. The family doctor, of course, had received a commission on all the fees collected, in addition to his own bill.

No less reprehensible, though more frankly brutal, was the conduct of the noted surgeon in the following case of appendicitis, which I select from scores of similar instances because of the unusually high reputation of the hero thereof:—

Mr. and Mrs. K. were a young Chicago couple just beginning to get a start in the world. Their little home was partly paid for. Only a thousand dollars was needed to clear off the mortgage, and this they had succeeded in getting together, by dint of much saving and self-denial, when the wife suddenly developed an acute attack of appendicitis. Her husband was greatly alarmed, and made enquiries as to who was the best surgeon in Chicago. He was recommended to one of the best surgeons in the country, whom we will call Doctor Y. So he rushed to the doctor's office and begged him to come at once to see his wife. Doctor Y. said he would come without delay, and the young husband hurried home to await his arrival.

Meanwhile, Doctor Y. made enquiries over the telephone as to K.'s financial condition, and soon found out about the thousand dollars in the bank. With this information, he visited and examined Mrs. K. The case was one of acute (catarrhal) appendicitis, as he had conjectured from the somewhat incoherent description of the husband. Turning to the latter, he said in his very forceful and emphatic manner:—

"This is a bad case of appendicitis; if she is not operated on at once, she will die."

The reader can imagine the consternation that ensued. Of course the husband implored the doctor to do everything possible to save his dear one's life. This was the psychological moment, as Doctor Y. well knew. So he replied, brusquely:—

"All right, Mr. K., the operation will cost one thousand dollars, and I must have the money before I begin."

Poor K. gasped. He knew that great surgeons do not ordinarily operate for mere glory or gratitude, but he had never expected anything like this. His struggle was short, however, for he loved his wife. Doctor Y. was the best surgeon in Chicago, and Mrs. K. should have his services as long as he could foot the bill. So with a sigh of regret as he thought of the home passing from them, and of the years of hard struggle to come, he agreed to the doctor's rapacious fee. Doctor Y. came again that evening with his assistants, and performed the operation, and performed it well. It was all over in less than twenty minutes, and when he left the house he carried Mr. K.'s hard-earned savings.

Doctor Y. is unquestionably a great surgeon. His skill and fame have brought him cases from all over the country, and he is a wealthy man. He did not need this thousand dollars; it meant almost less to him than a dollar meant to the poor clerk. How much manlier it would have been to have offered to take the patient to his clinic and operate on her free of charge, or else to have performed the operation at the house for a nominal fee of, say, a hundred dollars! But that would not have been "good business," and personal sacrifices, unless of a spectacular character, do not often appeal to the rich and famous.

It must have been the knowledge of such cases as this that led Dr. George F. Butler[1] (of Wilmette, Illinois) to write:—

> "The 'commercialism' of treating a patient unnecessarily, of taking advantage of his misfortune to frighten him into being treated indefinitely or operated on unnecessarily for the sole purpose of extracting a little more money from him, is not 'business'—it is downright dishonesty. The physician who prostitutes his profession by frightening and then *literally* robbing the sick is a more contemptible robber than the 'footpad.'"

Similar incidents must have come to the notice of a certain New England clergyman who was recently provoked into exclaiming:—

> "It is not a profession, it is a trade that the doctors ply to-day. It is not the practitioner of a profession who goes into a household and demands his fee of five hundred or a thousand dollars before he will apply his knife to the cancer, the anæsthetic to the wound. Such practices ought to be condemned from every pulpit—every rostrum in the land. The government ought to step in and prevent them."

Dr. A. Stuart M. Chisholm (of Bennington, Vermont), to whom this gentleman's ideas of administering anæsthetics afford no little amusement, regards such attacks as unwarranted and malicious, and attempts to prove by illustrious examples both from history and fiction, that because medicine has produced men of the noblest and most self-sacrificing type, the profession to-day must, of necessity, have preserved its ideals.

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[1] "Commercialism in Medicine." From the *American Journal of Clinical Medicine,* March, 1910.

"The study of medicine," he informs his assembled confrères,[1] "is an entrancing subject, its practice requires an array of virtues whose mere contemplation staggers the mind. One must meet violence with gentleness, ingratitude with equanimity, insult with fortitude, slander with silence. The physician's life is a daily exemplification of the Golden Rule."

Dr. A. J. Charlton, (of Bennett, Iowa) goes Doctor Chisholm one better, in a letter to the *Journal of the American Medical* Association (April 4, 1908), in which he replied with more heat than argument to the attack of Mr. Bok, of the *Ladies' Home Journal*, upon practitioners who, through ignorance or for profit, prescribe nostrums and proprietary remedies of uncertain composition. "The medical profession," exclaims this irate Westerner, "is an institution devoted to the spiritual, mental and physical condition of the people, therefore all but holy." And in conclusion:—

> "It is little wonder that the public is nonplussed as to a course of action when the leading publications of our day approach them with the gravest kind of accusations against the noblest and best of our professional men, the average physician. Happily, however, the inaccuracy of these accusations is real to any layman who may stop to think, and the horror of the unsubstantiated charge is being largely replaced by a new and everlasting confidence in the members of the profession who have so patiently and painstakingly served the people. . . ."

In reply, the editor of the *Journal of the A. M. A.*

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[1] "On the Inherent Spirit of Medicine." A paper read before the Medical Association of Troy and vicinity and published in the *Albany Medical Annals*, August, 1908.

points out that unfortunately Mr. Bok's accusations are only too true. "The letter quoted above," he states, "is the only communication we have received expressing disapprobation of Mr. Bok's paper and of its publication." And he adds:—

"The time has passed when we can wrap ourselves in a cloak of professional dignity and assume an attitude of infallibility toward the public. The more intelligent of the laity have opinions on medical subjects—often bizarre, it must be admitted, but frequently well grounded—and a fair discussion of such opinions can result only in a greater measure of confidence in, and respect for, the medical profession."

Before returning to my narrative I cannot resist quoting the testimony of another Westerner, Dr. Charles W. Oviatt, of Oshkosh, Wisconsin, the President of the Western Surgical and Gynecological Association. In his address delivered before this association at St. Louis, December 30, 1907, Doctor Oviatt said:—

"The spirit of graft that has pervaded our ranks, especially here in the West, is doing much to lower the standard and undermine the morals and ethics of the profession. When fee-splitting and the paying of commissions for surgical work began to be heard of something like a decade ago, it seemed so palpably dishonest and wrong that it was believed that it would soon die out, or at least be confined to the few in whom the inherited commercial instinct was so strong that they could not get away from it. But it did not die; on the other hand, it has grown and flourished."

Here, the reader will note, there is no hedging or supplementary qualification, and scores of outspoken practitioners and surgeons might be quoted to the same effect.[1] I prefer, however, to give further concrete cases, examples of heartlessness and "graft" which, if not of every-day occurrence, could easily be duplicated by any doctor—any *city* doctor, I suppose I must say—in the land. This, of course, will be contradicted by all who are guilty of dishonest practices, as well as by those self-deluded members of the profession, who think, like our friend of Bennett, Iowa, that loudly to deny the present tendency will by some strange process restore us to the "all but holy" state from which we have fallen.

When a young graduate in medicine hangs out his sign in a large city he must not expect, as a rule, to make his expenses for at least a year. Sometimes, however, fortune provides an early opportunity for him to distinguish himself. Such a chance befell a certain young physician in New York a number of years ago. He had been practising only a short time —that is to say, he had taken an office and displayed his sign,—when it happened, one day, that being the only doctor available he was called by a rich family to attend a young woman for some abdominal complaint. The young doctor soon found that the trouble was insignificant, but he felt that to release his hold on such a case so quickly would not be good business. Accordingly, he looked grave, and after a prolonged examination, anounced that the patient was really in a very serious condition which required immediate operation. As he was a good talker and possessed unlimited "cheek," he succeeded in winning the confidence of both patient and family, and soon secured their consent to an operation. He lost no time in performing it, sewed up the wound, and, after a period of after-treatment, sent in a bill for two thousand dollars. The exorbitant charge was paid without a murmur. The grateful family were made to believe that this able and prompt young surgeon had saved their dear one's life, and for such a service no price that they were able to pay was too high.

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[1] See Appendix F, and note remarks of Dr. Channing W. Barrett in Appendix G.

Before the patient had quite recovered, however, the shrewd surgeon discovered a complication that demanded another immediate operation. Having gained the complete confidence of the unsuspecting family by his first remarkable success, his word was now law in that household. A second operation was performed, and a second bill for two thousand dollars duly honored. Then finding the game so easy, he played it for all there was in it. It seems incredible, but he actually succeeded in inducing that poor, rich victim to undergo another abdominal operation at the same modest figure.

Whether the family became disillusioned after the third operation, or whether the young surgeon feared to tempt the devil once more, I cannot say. He went abroad almost immediately afterwards, took a special course in surgery, and returned to America well equipped, both professionally and financially. He owes his start to this one case which he handled (or rather mishandled) with such consummate effrontery.

An acquaintance of mine, a member of the New York Academy of Medicine, with whom I worked for some years, called me up on the telephone one day and asked me if I would assist him in a minor operation, a so-called curettage (scraping of the womb). He said that he might use a little chloroform, and in case he did he wished to have me present to administer it. The patient, by the way, was the wife of an assistant cook at one of the large hotels, and they lived in a small and inexpensive apartment. On our arrival he explained to the woman that he had brought his assistant and his nurse along, for he never operated unless they were present.

The poor people were very much frightened; they seemed to think that the operation was more serious than they had been led to expect, and asked if it could not be done without the use of chloroform. The surgeon explained that it could, but that if he employed cocaine, it would cost twenty-five dollars more, as cocaine was very expensive. The poor patient decided after talking the matter over that she would prefer cocaine to the chloroform. So cocaine it was to be, but unfortunately was not, as the doctor found that he had none. Nothing daunted, however, he performed the operation without administering any anæsthetic, simply swabbing the end of the uterus with sterilized water out of a four-ounce bottle, which he had brought with him, and which was supposed to be a cocaine solution. The woman suffered considerable pain, but bore it bravely as women will.

After everything was completed the surgeon informed the husband that he would be in to see the case on the following day, but that he would like to receive his fee as soon as possible; in short if the man would pay him there and then it would be quite agreeable to him. When asked what his fee was, he said that he generally charged two hundred and fifty dollars for an operation of that kind, but seeing they were people of limited means he would make it seventy-five dollars, and twenty-five for the cocaine solution which he had used. The whole thing would be one hundred dollars. The operation might have been worth seventy-five dollars, that we will not discuss, but to charge twenty-five extra for cocaine solution when he had simply swabbed the parts with sterilized water was downright rascality, and I did not hesitate to tell the gentleman so.

Mrs. J., a former patient of mine, related the following story, which I give in her own words. It exhibits a depth of brutality that few even of the most callous surgeons would, for business reasons, care to display:—

> "You see, Doctor, my husband is an ice man and he works all day. I was to be scraped because I was bleeding badly every month. The doctors came to my house and gave me chloroform, and before I was out of it, they shouted in my ear and wanted their money. I did not know very much what I was doing, for I was hardly out of the chloroform, but I pointed to the dresser drawer where all our savings were kept. They took what they wanted and went away and left me alone. My husband came home and found me insensible on the floor. I had fallen off the bed and sprained my arm. My husband had to call in another doctor to attend to me, and was very angry at the first two for stealing our money and leaving me the way they did."

One wonders where such heartless wretches were educated, and if they chose a medical career with the intention of exploiting the weak and unfortunate. With all the shortcomings of our system of medical education, surely no institution exists that deliberately inculcates a cynical indifference to suffering and distress. On the contrary, many students receive the most wholesome counsels, and not a few leave their beloved Alma Mater inspired by the highest ideals. To what, then, can we attribute their downfall, but to this all-pervading spirit of "graft," and to the unscrupulous and heartless practices of those high in the profession? Thus the doctor of standing who stoops to dishonest or questionable methods does a double wrong, one to his patient, and one, by example, to the younger practitioner, who is only too ready to conform to "modern" standards.

I cannot conclude this chapter better than by quoting from a recent article by Dr. Arthur C. Haffenger in the *North American Review*[1]:—

> "There are a few men in every profession who sully the ranks to which they belong by resorting to methods that are unworthy and ignoble; but such men are held in obloquy by their confrères, and are soon estimated at their true value by the community. These men are truly commercial and devoid of either professional or personal honor. They magnify trivial ailments, or convince patients that they have ills which do not exist, in order that they may get credit for performing remarkable cures, charge large fees, and gain unmerited reputation. This is pure quackery, though done under the cloak of regular practice, and the culprits are not confined to the lesser lights of the profession, but may be found among the most fashionable practitioners in metropolitan centres. They are often specialists and, to get patients, are willing to resort to collusion with general practi-

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[1] "The Medical Fee." From the *North American Review*, November, 1908.

tioners, who, envious of the large fees they think the specialist gets, openly demand, before referring a patient, a division of the consulting or operating fee. Language is not strong enough to condemn such nefarious methods, and, happily, incidents of the kind are rare."

To all of which I subscribe, except the last line—unhappily incidents of the kind are only too common.

# CHAPTER II

## "ETHICS" REAL AND CRIMINAL

"We understand by 'ethics' the general doctrine of the duties of life, and the prefix 'medical' would seem to have a limiting effect, and to imply the consideration and formulating of such duties only as might arise from, and be peculiar to, the relation between the medical profession and the persons about whom they are required to exercise their skill or to deliver their opinions. . . . But practitioners will remember that the whole of so-called medical ethics is covered by the edict approved equally by the Law and the Prophets and Buddhistic authority that a man should do as he would be done by."
—The London *Lancet*.

The respectable physician of to-day is known among his confrères as an ethical practitioner. This may mean a great deal and it may mean very little. The old code, now known as the "Principles of Ethics," which has the sanction of the American Medical Association as well as of many state organizations, is a document of several thousand words, divided into three sections, one on "The Duties of Physicians to their Patients," the second on "The Duties of Physicians to Each Other," and the third on "The Duties of the Profession to the Public." Like other obsolete codes, it contains many admirable provisions (which, of course, cannot be enforced, since these "principles" are only "advisory and suggestive"), much that is ambiguous and absurd, and not a few regulations that are palpably selfish, and in direct opposition to that higher morality which finds its expression in the Golden Rule. In short it is a hodge-podge of ethics, etiquette and tradition, delivered with a senile sententiousness that has caused no end of merriment both within and without our ranks.

The editor of the *Medical Record*, getting facetious upon the subject, draws attention to "the wishy-washy style" and "ludicrous phraseology" of "this unequalled collection of Tupperian platitudes," and adds: "it is inconceivable that a body of practical men, hard-headed, and endowed, we trust, with a saving sense of humor, will write themselves down—subscribers to these Sandford-and-Mertonish moral maxims."[1]

That the code has not stemmed the rising tide of graft and commercialism, we have seen; that it frequently discourages meritorious effort, handicaps the young practitioner, brings discredit upon the most disinterested investigators and almost invariably shields the callous or incompetent doctor from publicity and consequent disgrace—these are the common charges against our accepted "principles," charges, I fear, that can only too easily be proved.

As already pointed out, the code is merely "suggestive and advisory"; hence it has come to be regarded as a dead letter by those who have sufficient influence or prestige—a dead letter, that is, so far as their own affairs are concerned, but a law to be rigidly enforced against the younger or less influential practitioner. Physicians are enjoined to preserve the most fraternal relations, yet the code, by its elasticity and ambiguity, is itself one of the greatest causes of discord. One physician, for instance, must not question the practice of another toward a patient, no matter if a life is at stake, yet they may discredit one another among the profession upon the merest quibble of etiquette. The result is that rancor and jealousy find their outlet in trumped-up charges of "unethical procedure," and the letter of the code is applied as rigorously as if the offence were a crime of the first magnitude.

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[1] *Medical Record*, January 27, 1906. The editor is here referring to the members of the Medical Society of the State of New York.

The young men, of course, are the greatest sufferers. Let a fresh arrival from college transgress one of these official rules, and no matter how promising his career may be, or how minute the transgression, the older practitioners can ruin his reputation. A more punctilious rival may be guilty of the grossest malpractice, yet, if he observe the professional proprieties as interpreted by the local society, he receives the utmost consideration from his associates. Indeed, a doctor whose record is but a succession of dismal failures, may not only stand high in professional circles but may be instrumental in causing the removal of the best practitioner in the community if the latter has been so unfortunate as to confound ethics with "medical ethics." For example, Doctor A., finding that Doctor B. has lost a patient through carelessness or stupidity, may forfeit his career if he so much as hints at the truth to the victim's family. The first offence—killing a patient—is a mere transgression of the moral law; the second violates the higher law of "medical ethics" and is unpardonable. Hence A. continues his practice, maiming and killing as he pleases, while the over-zealous B. moves away to try and live down his disgrace.

A fair illustration of the dual application of the code can be seen in the attitude of an old and a young practitioner toward publicity. A doctor of twenty years' experience may write medical articles and see that they are circulated among his patients, but should a young man attempt such a thing, the local medical society would look upon him as an advertising quack, and the stigma might cling to him for years. The older men, too, may be interviewed by the newspapers, and are at times only too glad to see themselves quoted on some new topic of medicine in the various morning papers. Some of our ablest surgeons in New York and Philadelphia have begun the practice in recent years of contributing popular articles to lay periodicals, though much to the surprise and disgust of others who have not sufficient reputation to permit of their gaining equal publicity.

An able Vienna surgeon came to this country a few years ago to teach us a lot of new things, and incidentally to make a big fee, with liberal publicity thrown in. This gentleman gave public clinics and permitted himself to be interviewed, and he was able to disregard " ethics " because of his international reputation. Had he lived up to the code either of his country or of ours, he would have performed his work quietly and departed with reserve and dignity. His visit might not have been so profitable had he done this, but he would certainly have left a better impression upon the profession.

So much for a celebrity. His methods may meet with disapproval, the profession at large may be perfectly aware that he has sought publicity, yet no voice of protest is raised. But let a lesser light transgress, even unintentionally, and we have a rare exhibition of professional tyranny. The case of Doctor Denslow well illustrates this.

Dr. Le Grand N. Denslow is a reputable New York physician who had made an investigation, covering many years, into the cause of locomotor ataxia. He finally discovered what he believed to be a cure for this disease and was permitted to read a paper before the Academy of Medicine telling of his work and the alleged results. This the newspapers got hold of, and as Doctor Denslow had no commanding influence he was severely criticized on all sides. His efforts were held up to ridicule, and his very character was assailed, not only by his colleagues in New York, but by the influential *Journal of the American Medical Association.* Commenting upon the occurrence, the editor of *American Medicine*[1] said:—

> "Intolerance, once again, arises to shame the medical profession. Dr. Le Grand Denslow, a New York physician who has been directing his studies to locomotor ataxia, recently gave a report of his investigations to his colleagues. With admirable professional spirit his work and the results he has obtained were submitted to the profession at the Academy of Medicine. Several of the better class of newspapers, following a growing custom that is being fostered in the highest circles, referred to Dr. Denslow's researches, and immediately a storm of criticism arose. Medical men who knew absolutely nothing of Dr. Denslow's work rushed into print to deny the 'possibility' of his results, to question his diagnoses, and apparently to throw all the discredit possible on his efforts. History, therefore, has repeated itself, and just because a man has dared to attack a dis-

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[1] *American Medicine,* October, 1908.

ease that has been held incurable, he has had to run the gauntlet of suspicion, reproach and jealousy. This is all wrong. How much more worthy of modern progressive medicine it is to approach Dr. Denslow's work with an open mind, trusting to our scientific knowledge to appraise it at its true value, and to accept it or reject it as our judgment dictates! It is absolutely certain that time and experience will either place these ideas of Dr. Denslow's on a secure footing or consign them to oblivion. He submits well-established data confirmed by recognized authorities, for the consideration of the profession. In the meantime he courts investigation and seeks co-operation to the end that the truth shall be ascertained. Can the medical profession do any less than meet such a spirit half way?"

More than two years have elapsed since this incident, but Doctor Denslow is still *persona non grata* with many sticklers for the ancient code. Indeed plenty of less brilliant men who have technically acquired the reputation of self-advertisers have never been able to live down the disgrace. Yet when such publicity comes to men like Doctor Keen of Philadelphia, who has written many surgical articles for the lay press, or to Dr. S. Weir Mitchell, or Dr. Woods Hutchinson, does anyone imagine that the members of the Academy of Medicine or their county societies would pay any attention to it? Punishment is meted out only to those who can't resist, and very often the worst offenders are the foremost in the prosecution—or shall I say the persecution?

I am sorry for the many worthy victims of this "ethical" machine, for I believe they are often earnest and progressive men who ought to receive every encouragement from the less intelligent, and hence more conservative, rank and file.

Compare Doctor Denslow and his disinterested labor —even if the results are not what he anticipated—with Doctor M., whose record as an operator would have created envy in the Spanish Inquisition. Yet Doctor M. is a member of one medical society, at least, and if Doctor Denslow's name came up for membership, he would have the effrontery, I suppose, to object to his election on " ethical " grounds.

The following atrocity, committed by Doctor M., should by rights take its place in a later chapter among surgical outrages, but I wish to emphasize the ethical aspects of the case and show that whereas ethics—the common and garden variety—and crime are as far asunder as the poles, " medical ethics " and crime may be found in the closest proximity.

Doctor M. is a surgeon practising in New York. He is one of the operating surgeons of a large city hospital and had gained considerable reputation at the time the following events occurred.

He was consulted one day by an Italian woman, living in Brooklyn, who complained of a swelling in her abdomen. After going into the history of the case and examining the woman very carefully (according to his methods), Doctor M. made up his mind that his patient was right—there certainly was a " swelling " in the abdomen. The woman, he learned, had borne a child six or seven months previously, and as another pregnancy did not suggest itself he diagnosed the case as " fibroid " tumor of the uterus. The people were ordinary foreigners with very little knowledge of English and less of surgery. Whatever Doctor M.

elected to do would be right because he was the " great Professor."

Certain of his diagnosis, Doctor M. decided to operate, and chose a private hospital on —— Street for his purpose, an institution where many well-known surgeons send their patients, but where he, for good and sufficient reasons, has never been invited to send another.

Now as Doctor M. was anxious to make a great name for himself in surgery, he invited Doctor V. and Doctor X. to witness the operation, while Doctor Y. assisted and Doctor Z. gave ether. There were other onlookers, two nurses and the woman who owned the hospital.

After due preparation the case was ready for the knife, but as the patient walked into the room, clad in a single garment, all present, except the operator, were struck by the typical signs of pregnancy. The impression of pregnancy instead of fibroid tumor of the uterus was further strengthened by the appearance of the woman's breasts. The visiting doctors exchanged glances of surprise, and when anæsthesia was begun, my friend Doctor V. said to Doctor M.:

" Pardon me, Doctor, but may I ask if you have made a careful examination which will absolutely exclude the possibility of pregnancy? "

Doctor M. looked up quickly, evidently highly insulted, and replied: " I am surprised that you should dare to put such a question to me, Sir. If you were not a personal friend I would ask you to leave the room."

After such a rebuff there was nothing more to be said—the code enjoined silence. Doctor M. apparently considered himself infallible. And so the operation was begun.

The self-willed surgeon made an incision and cut down to the uterus as quickly as possible. After examining it at that stage he should have suspected the true state of affairs, but he lacked surgical experience and so obstinately blundered ahead.

When the uterus was finally delivered and triumphantly handed round for examination, Doctor V., still sceptical as to its diseased condition, took up a knife and carefully bisected it. Then the hideous truth was revealed: to the dismay of Doctor M. and the apparent astonishment of his "ethical" associates, the "fibroid" proved to be a living fœtus. Doctor M., much crestfallen, took the uterus home and has it now, I understand, in a glass jar in his office. The fœtus and afterbirth, of course, were quietly destroyed.

The poor patient eventually recovered, but is still in ignorance of the monstrous blunder that was committed. For the spectators of that dastardly affair have remained silent—"ethics" prevents their saying anything. And Doctor M., confident that the truth will never be divulged, has actually been heard to boast of his successful "fibroid" operation!

Everyone in that room was a slave to "ethics," hence after the one suggestion from my friend, every mouth was sealed. Doctor Y., who assisted, told me that he knew it was a pregnant uterus as soon as he felt it, and Miss R., who owned the sanitarium, said that she knew by the condition of the woman's breasts that she was pregnant. Yet neither could argue this possibility with the opinionated surgeon, and the idea of vigorously opposing him in the interests of a human life probably never once occurred to any of the spectators. If there had been less "ethics" and more common sense and humanity, the patient could have been sewed up and might still have gone to term and had her baby.

The same mistake was made by a surgeon in Los Angeles, but the case was more difficult to diagnose. As soon as he felt the gravid uterus he closed the abdomen up again. The woman made a rapid recovery from the operation and had her child in due time. In both cases mistakes in diagnoses were made, but one surgeon had the brains and moral courage to act the man in the emergency, while the other had not.

I do not mean to say that such revolting cases as the one I have just given are of everyday occurrence; nevertheless it is no exaggeration to say that thousands of lives are sacrificed every year on the altar of "medical ethics." No one is infallible—not even the greatest surgeon, as will be amply proved in a later chapter—yet innumerable tragedies can be laid solely to this false and inhuman idea of dignity. Of course, it is essential that a certain form of etiquette should be observed, and that proper deference should be shown to the family physician. No one questions that the practitioner or surgeon in charge of a case has his rights; all I insist on is that the patient likewise has his rights—the poor, helpless creature entering the valley of the shadow of death, trustfully relying on the skill and humanity of the doctor of his choice. Surely to ignore a hint from an associate, or even from the watchful nurse, that would aid in the battle with the grim destroyer, and particularly to do so from any consideration of prestige or reputation—such conduct, I assert, is a brutal, damnable betrayal of a sacred trust.

One is tempted to say that to the average doctor "ethics" is in inverse ratio to manhood, but this would be hardly fair. The recognized code unquestionably serves a useful purpose; the evil lies mainly, as we have seen, in the confusion of ethics and etiquette, and in the undue prominence given to what at best can be regarded as "red tape." As a speaker in one of G. Lowes Dickenson's political dialogues says: "I don't dispute your facts; I dispute your emphasis."

Turning to Article IV of the "principles," dealing with consultations, we read:—

> Section 5.—"In consultation no insincerity, rivalry, or envy should be indulged; candor, probity, and all due respect should be observed toward the physician in charge of the case."
>
> Section 9.—"All discussions in consultation should be held as confidential. Neither by words nor by manner should any of the participants in a consultation assert or intimate that any part of the treatment pursued did not receive his assent."
>
> Section 11.—"A physician who is called in consultation should observe the most honorable and scrupulous regard for the character and standing of the attending physician, whose conduct of the case should be justified, as far as can be consistently with a conscientious regard for truth, and no hint or insinuation should be thrown out which could impair the confidence of the attending physician."

Now let us see how this works out.

Doctor So-and-so, we will say, has made a mistaken diagnosis and given wrong treatment till the precarious condition of his patient arouses him to a realization of his mistake. If he is wise he will instantly consult with another physician, but if he is too headstrong to do this the family will probably demand a consultation.

If he takes the initiative and calls in an acquaintance, it is almost an absolute certainty that the latter will agree with all that he has done, since he has everything to lose and nothing to gain under the circumstances by irritating or antagonizing an associate. If a stranger is summoned, the case is somewhat different. This doctor will see the patient, talk learnedly about the malady, and then assure the distressed family that their physician has done about the right thing, though owing to a complication that has apparently just arisen he would suggest a certain modification of the treatment which he will communicate to the physician in charge. Upon leaving, if he is a stickler for "ethics," he will deliver himself somewhat as follows:

"I think, on the whole, Doctor So-and-so has done all that could be expected. I have left some minor suggestions for his consideration, but I do not think you could do better than retain his services."

And so the farce is over and the patient perhaps doomed, simply because the code values a doctor's reputation and dignity above a human life.

Of course, things do not always run thus smoothly between doctors, for the man who is influential enough to ignore "ethics" does not at all object to seeing his rival discredited. Thus he may interfere with the treatment of the case, where he has been called in consultation, simply to enhance his own reputation, and not necessarily in the interests of the patient at all.

Here, as already stated, the older practitioners are the worst offenders, and many and pitiful are the complaints of younger practitioners of "unethical" treatment at the hands of their professed superiors. Writing of this phase of the matter in the *Lancet-Clinic*,[1] Dr. Edwin J. Kohoe (of Cincinnati) says:—

> "But to the case-stealing old doctor must go the palm for nabbing patients. He has the confidence of the people, and can by a significant glance, or a seemingly harmless bit of advice, purloin your case with the dexterity of the artful dodger. It is an undeniable fact that the longer a man is in practice, the greater are his opportunities for good or evil. He is regarded as the very soul of honor by his clientèle, and when such an one becomes so morally depraved as to use their confidence for the furtherance of his own selfish interests at the expense of his colleagues, it is enough to make the angels weep, and should bring upon the head of the offender the strongest condemnation of the profession."

Such cases are no doubt aggravating in the extreme, yet if the angels are permitted to gaze into our sick chambers and hospitals one cannot help thinking that they will find other matters to engage their sympathies than the distress of an over-dignified physician at the "unethical" conduct of his rival.

To sum it up, the official "principles of ethics" seem so contrived that the doctor who is possessed of any sense of honor is forced to stifle his humane impulses and at times connive at the grossest malpractice, while the "grafter" may take refuge under the code to-day, and to-morrow violate it both in letter and in spirit.

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[1] "Medical Ethics."—The *Lancet-Clinic,* July 24, 1909.

The time is not far distant, however, when the expression " medical ethics " will have been swept from our vocabulary except as a term of reproach for the absurd and iniquitous code that we so long tolerated. Unless I am much mistaken the code of the future will be nothing more pretentious than a simple, common-sense manual of professional etiquette, and will be so regarded, while ethics will mean, as it always has meant to an honorable minority in the profession, ***the universal application of the Golden Rule.***

# CHAPTER III

## EDUCATION AT THE COST OF HUMAN LIFE

"The physician, above all others, is the man whose education should be broad and complete. To him are intrusted the lives of his fellow-men, and half-baked youngsters without preliminary mental training should not be permitted to travesty so serious a profession."—*Milwaukee Sentinel.*

If you, reader, should lose a dear one—let us say an only child—and it should transpire that the young doctor in attendance blundered, in fact killed your child by his stupidity, you would in all probability upbraid him for his incompetence and then go home to nurse your sorrow. Which would put you, intellectually, very much on a par with the offending medico. He, in his ignorance, did not recognize the disease and was blinded by symptoms; you in your sorrow and indignation are equally blind to the doctor's trouble and so condemn him on the first appearance of symptoms for which he is only indirectly responsible.

That young doctor, I find, graduated just three months ago. His college is situated in a small town where there is no dispensary and but a make-believe hospital. The town physicians, many of whom have graduated from similar institutions, are its "professors." There are no laboratories, only rarely can a cadaver be secured for dissection, instruction has to be by the didactic method, and preparation for the state examinations—which is the one animating purpose of the institution—is principally effected by "machine cramming," aided by hasty excursions to the clinics of a near-by city.

"Ah," but you say, "if the state examinations are thorough the incompetents will be weeded out."

To which I would reply that the very existence of state examining boards proves a distrust of the standards of our colleges. And it is surely self-evident that where a state ignores the methods of an educational institution and makes a few hours' examination the supreme test of efficiency, the tendency on the part of the college will likewise be to wink at methods and concentrate all its energy on circumventing the restrictions imposed.

Of course, it has long been known within the profession that our whole medical system (or rather, lack of system) of education is wrong; that despite the brilliant work in many of our laboratories, despite the host of conscientious, up-to-date young doctors that our best institutions have turned out, medical education and ideals are lower in this country than in almost any part of Europe, or in our immediate neighbors, or in Japan or Australia or the Argentine Republic. On the average, our doctors know less and blunder more than the medical profession in any other civilized country, and the reason is that the medical colleges here are, on the whole, so far below the standard set by the rest of the civilized world that it shames us to make the comparison.

As I say, these facts have long been known to our medical leaders, and bitterly deplored, but the investigations of the American Medical Association which covered several years and have lately been announced, and the exhaustive work of Mr. Abraham Flexner of the Carnegie Foundation, which has recently been published as Bulletin No. 4, leave the public no further excuse for their ignorance of, or apathy toward, the conditions that prevail.[1]

Now let us face a few stern facts.

First and last, according to Mr. Flexner, this country and Canada have produced four hundred and fifty medical schools, all practically within a century. This is probably a much greater number than have ever existed throughout the rest of the world. "Fifty of these were still-born," and since only a hundred and fifty are to-day in existence it follows that three hundred have come and gone, leaving their ghastly traditions behind them and a host of incompetent and often unscrupulous graduates to prey upon the sick and wretched, and augment the forces of ignorance and disease.

Fortunately the number is still decreasing. The American Medical Association reports that in the six years ending June 30th last, no less than forty-five went out of existence or were merged with stronger institutions; but since twenty-three were organized during this period we have a net decrease, for this country, of twenty-two. The *Carnegie Foundation Bulletin* gives the present number as 155, but this report has received such widespread publicity and has created such a storm of indignation that at least half-a-dozen have since dropped out, while it is safe to say that scores of the weaker institutions contemplate either dissolution or complete reorganization.

Some of these defunct schools, of course, were conscientiously conducted, and failed either from lack of funds or because disadvantageously situated. But the majority were commercial ventures, pure and simple, that accepted all applicants and moved them on as quickly to make room for more. Of such was the Gate City Medical College, located in Texarkana, near the state line between Arkansas and Texas. This institution, which sent out a circular offering a Home Reading Course by mail for $25.00, upon the completion of which a " special diploma " would be granted, was investigated by the Arkansas Medical Society and mercilessly exposed in the journal of that society, August, 1907. The report, in part, was as follows:—

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[1] President Henry S. Pritchett's Introduction to Mr. Flexner's voluminous report is given in Appendix A, and deserves a most careful perusal.

" A medical college organized and launched in the midst of an era of the greatest medical energy and progress the world has ever known, (a) that has practically no educational requirement for admission; (b) that is without an anatomic laboratory; (c) that does not require its students to dissect; (d) that makes false representations in its catalogues, thereby attracting many students; (e) that is without sufficient hospital advantages, thus depriving students of the best means of studying diseases clinically; (f) that gives lectures by mail for which credit is given; (g) that is conducted dually, brazenly, irregularly and unprofessionally, in a Dr. Jekyll-and-Mr. Hyde manner, should meet its just reward at the hands of the courts. The ' stigmata ' of fraud were so much in evidence as to warrant the conviction that not only is Dr. Decker (the dean) guilty of unprofessional conduct meriting the unqualified condemnation of the profession, but the charter under which he is authorized to conduct his school should be summarily revoked by the Arkansas and Texas authorities, thereby putting an end to a brief but disgraceful chapter in the history of an Arkansas-Texas medical college."

The publicity given to this report, as may be imagined, finished the Texarkana correspondence scheme, and so we may feel encouraged to hope that the Carnegie Foundation report will do a like work for the whole country, weeding out the many other undesirable institutions, which, if not quite on a level with the "diploma-mills" of the past, are certainly a disgrace to a civilized country and a menace to the health and lives of the people. The night schools, for instance, of which Chicago furnishes a typical example in the Jenner Medical College, are unquestionably doomed. Mr. Flexner describes this institution, as he found it in April of last year, as follows:—

> "Jenner Medical College. Organized 1892. A night school, occupying three upper floors of a business house. An independent institution.
>
> Entrance requirement: Nominal compliance with state law. A one-year pre-medical class is operated by way of satisfying the law.
>
> Attendance: 112.
>
> Teaching staff: 37, of whom 28 are professors.
>
> Resources available for maintenance: Fees, amounting to $12,880 (estimated).
>
> Laboratory facilities: The equipment consists of a meagre outfit for chemistry, a somewhat better equipment for physiology, though no animals were to be seen, and a slight outfit for pathology and bacteriology. Anatomy is taught by lectures 'with the cadaver' from the beginning of the year until May 15, after which there is 'dissecting until the close of the year.'
>
> Clinical facilities: Clinical facilities are practically nil,—one or two night clinics being all that the school claims to offer. The school once had access to Grace Hospital, a private institution of 30 beds; but it has

recently been turned out for failure to pay for the privilege.

The dispensary attendance varies from two to ten, four nights weekly. No particular rooms for dispensary purposes are provided: 'patients are taken right into the rooms where the classes are.'

An out-and-out commercial enterprise. The instruction is plainly a quiz-compend drill aimed at the written examinations set by the state board of Illinois and of other states."

"If there is any city in the country," writes Dr. Murray Galt Motter (of Washington, D. C.),[1] "where a night school of medicine might find a reasonable excuse for existence, it is, perhaps, the city of Washington. The offices of the several governmental departments swarm with ambitious but underpaid clerks, many of whom work at their desks from 9 until 4:30, and many others seek to profit by the much-vaunted educational advantages of the National Capital from 4:30 until 9."

Making every concession to the advocates of such apparently useful institutions, Doctor Motter nevertheless sides against them. The following is his conclusion:—

"Whether or not it is possible thus to serve two masters, without slighting the work of one or the other, it must, in sheer justice, be said that many able and capable men have entered the profession by this route. To-day, however, when the medical curriculum cries aloud for more time and for the undivided attention of its followers, it is more than doubtful whether such a combined course can be followed either with safety or with profit. Could the medical course in such a school be extended to five or six years, the last year being devoted unremittingly to clinical work and, of course, in the daytime, but little criticism could arise. Competition, however, is so keen that the medical school which could not turn out an M.D. in four years at most would have scant patronage."

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[1] Read at the Sixteenth Annual Convention of the National Confederation of State Medical Examining and Licensing Boards, Boston, June 4, 1906, and published in the *Journal of the American Medical Association*, May 4, 1907.

Then there are the various sectarian schools, of which there are thirty-two. Some of these are good, according to the standards of the past, inasmuch as they give a moderate grounding in scientific medicine upon which they superimpose their particular dogmas. But the majority, while acknowledging the fundamental sciences, such as anatomy, physiology, bacteriology, etc., are hopelessly inefficient both in equipment and methods of instruction. Take Mr. Flexner's report of the Pulte Medical College of Cincinnati, for instance, which he visited in December of last year. This is a homœopathic institution, supposedly of the better sort. Mr. Flexner describes it as follows:—

"Pulte Medical College. Homœopathic. Established 1872. An independent institution.

Entrance requirement: A four-years high school education or its equivalent.

Attendance: 16.

Teaching staff: 36, of whom 24 are professors, 12 of other grade.

Resources available for maintenance: Fees, amounting to $1325 (estimated).

Laboratory facilities: Anything more woe-begone than the laboratories of this institution would be difficult to imagine. The dissecting-room is a dark apartment in the basement, in which (December 14) the year's dissecting had not yet begun; but the teaching of anatomy was not therefore halted. A disorderly room with a small amount of morbid material and equipment is known as the pathological and bacteriological laboratory. The chemical laboratory contains a few desks, with reagent bottles, mostly empty. There are a few old books in the faculty-room. No charts, museum, models, or other teaching accessories are to be seen.

Clinical facilities: There was formerly a hospital in the same building, but it is now closed. The school claims to hold clinics at certain private institutions, in which, however, the work is mainly surgical and the cases not free. Except by attending amphitheatre clinics at the city hospital, it is not clear that the Pulte students can regularly see any hospital medical cases at all.

There is an inexpressibly bad dispensary in the school building."

Of the eight eclectic schools only two are set down as passable. The following, which is situated in Atlanta,[1] is neither the best nor the worst:—

" Georgia College of Eclectic Medicine and Surgery. Organized 1877. An independent institution.

Entrance requirement: Nominal.

Attendance: 66.

Teaching staff: 20, of whom 14 are professors and 6 of other grade.

Resources available for maintenance: Fees, amounting to $5655 (estimated).

Laboratory facilities: The school occupies a building

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[1] Date of Mr. Flexner's visit, February, 1909.

> which, in respect to filthy conditions, has few equals, but no superiors, among medical schools. Its anatomy room, containing a single cadaver, is indescribably foul; its chemical ‘ laboratory ’ is composed of old tables and a few bottles, without water, drain, lockers, or reagents; the pathological and histological ‘ laboratory ’ contains a few dirty slides and three ordinary microscopes.
>
> Clinical facilities: The school is practically without clinical facilities. The outfit in obstetrics is limited to a tattered manikin.
>
> Nothing more disgraceful calling itself a medical school can be found anywhere.”

Yet the eight osteopathic institutions are, if possible, still worse, and so rankly mercenary in character that their clinical patients, even those who are treated by the students, are invariably charged for treatment. How much suffering humanity can hope for from a science of healing, the leading text-books of which are a ledger and a bank-book, the reader may readily conjecture. Summing up the work of the osteopathic schools, Mr. Flexner says:—

> “ The eight osteopathic schools now enroll over 1300 students, who pay some $200,000 annually in fees. The instruction furnished for this sum is inexpensive and worthless. Not a single full-time teacher is found in any of them. The fees find their way directly into the pockets of the school owners, or into school buildings and infirmaries that are equally their property. No effort is anywhere made to utilize prosperity as a means of defining an entrance standard or developing the ‘ science.’ Granting all that its champions claim, osteopathy is still in its incipiency. If sincere, its votaries would be engaged in critically building it up. They are doing nothing of the kind. Indeed, in none

of the sectarian schools does one observe progressive effort even along the lines of its own creed."

But the sectarian, or so-called "irregular" schools are only a fifth of the total, and so we must examine the "regular" institutions if we would know the true conditions of medical education. Here is Chattanooga Medical College, for example, as found by Mr. Flexner in January of last year:—

"Chattanooga Medical College, Chattanooga. Organized 1889. The medical department of the University of Chattanooga.

Entrance requirement: Nominal.

Attendance: 112.

Teaching staff: 25, of whom 11 are professors, 14 of other grade.

Resources available for maintenance: Fees, amounting to $4290.

Laboratory facilities: The school occupies a small building, externally attractive; the interior, dirty and disorderly, is almost bare except for a fair chemical laboratory in good condition. The dissecting-room contains two tables; the single room assigned to histology, pathology, and bacteriology contains a few old specimens, mostly unlabelled, and one oil-immersion microscope. The instructor explained that they 'study only non-pathogenic microbes; students do not handle the pathogenic.' There is nothing further in the way of laboratory outfit; no museum, books, charts, models, etc.

Clinical facilities: Amphitheatre clinics are held at the Erlanger Hospital, which averages about 50 free patients. Students may not enter the wards. Perhaps ten obstetrical cases annually are obtainable, students being 'summoned,'—just how is not clear. The students see no post-mortems, no contagious diseases, do no blood or urine work, and do not always own their own text-books. They use quiz-compends instead.

There is no dispensary.

This is a typical example of the schools that claim to exist for the sake of the poor boy and the back country."

Summing up his impressions of this class of schools, Mr. Flexner says:—

"As a matter of fact, many of the schools mentioned in the course of this recital are probably without redeeming features of any kind. Their general squalor consorts well with their clinical poverty: the class-rooms are bare, save for chairs, a desk, and an occasional blackboard; the windows streaked with dust and soot. In wretched amphitheatres students wait in vain for 'professors,' tardy or absent, amusing the interval with ribald jest and song. The teaching is an uninstructive rehearsal of text-book or quiz-compend: one encounters surgery taught without patient, instrument, model, or drawing; recitations in obstetrics without a manikin in sight,—often without one in the building. Third and fourth year men are frequently huddled together in the same classes. At the Memphis Hospital Medical College the students of all four years attend the same classes in many of the subjects taught."

"I wish," wrote Dr. Arthur Dean Bevan[1] (of Chicago), a couple of years ago, "that every member of the American Medical Association could have made the inspection of the medical schools of this country with our committee last year and seen the farce of attempting to teach modern medicine, as it is being taught in many schools, without laboratories, without trained and salaried men, without dispensaries and without hospitals. Schools were found which were mere quiz classes, where students were given just enough text-book knowledge to attempt state board examinations, and where the teacher looked for his compensation in consultations sent him by his illy-qualified pupils."

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[1] "Medical Education in the United States; the Need of a Uniform Standard." The *Journal of the American Medical Association,* August, 1908.

As already pointed out, however, the low-grade school is passing, for the simple reason, apart from the tardy action of our legislators, that the peculiar conditions that made it possible, and sometimes even useful, to our sturdy, pioneer civilization, have long since passed away. Of course, the energy with which we accelerate its departure may make a difference of thousands of lives, and I do not want to discourage action, but the law of supply and demand seems to have anticipated us by many years. As Doctor Bevan emphasizes in the paper already quoted from:—

"The supply of physicians far exceeds the demand. From the standpoint of demand, therefore, the excuse for low standards of medical education and of medical colleges operated for profit no longer exists. Medicine, too, has changed. The known facts of medicine thirty years ago might have been taught in a two years' course of didactic lectures by a few men. To-day the known facts in medicine, which must be mastered before a student becomes a qualified practitioner, require much more time, a thorough preliminary preparation, and a thorough laboratory and hospital training."

It is pleasing to note that this reform is not all from the outside, that some of the struggling little institutions which, in spite of their meagre endowments and scanty equipment, did really serve their day and generation, have voluntarily closed when they realized that their work was no longer of benefit to their state or community. Of such was the Nebraska College of Medicine, which closed its doors on May 19th of last year. In an open letter to the president of Nebraska Wesleyan University, with which the school was affiliated, Dr. J. F. Stevens, the dean, sets forth the reasons for dissolution in these words[1] :—

"We would respectfully call your attention to the fact that educators and physicians throughout the United States, recognizing the inferiority, on the whole, of the American medical schools, as compared with those of Europe, have determined to raise the standard of medical education to such a point that our colleges will command the respect of the world. While academic training and opportunity have grown into magnificent and commanding proportions, the professional schools, with the exception of a small minority, have remained essentially elementary or even worse. The spirit of progress has at last become supreme and on all sides may be seen the work of destruction, reorganization, and rebuilding. The American Medical Association is doing a splendid work in securing and digesting statistics, and reflecting the strengths and deficiencies of our institutions. The Carnegie Foundation, in a different manner, lends its words of wisdom, and a multitude of smaller bodies and societies, including state examining boards, are working together with hardly a discordant note, for the same purpose. Standards of entrance requirements have been raised to such a point that one full year's work in an accepted college or university is required for matriculation. Soon it will be two years, and later a bachelor's degree will, without doubt, be the *sine qua non*. Small colleges that have found it impossible to stand the strain of such requirements have been forced either to step from the field altogether, or to merge with some other school. In several states nearly, or quite, all of the small schools have been blended with the state institution. At the same time the requirement is going forth that schools shall have at their disposal a dispensary and hospitals sufficiently patronized to permit of a very wide study of disease. These requirements cannot be met in a small city. Again, with the rapid advancement in medicine has come the need of costly laboratories, under the direction of highly cultured men. Subjects, too, that once belonged to the 'mere mention' hour in the course of study, have developed into great fields with divisions and subdivisions, each demanding a special training for its comprehension and most certainly for its proper teaching. None of these requirements insisted on by educators and the medical profession generally is in excess of what it should be, and this institution is in full harmony with that view. . . . We fully realize that to maintain our standing and dignity as medical teachers, in the continuance of our college, it will be necessary to add to our working force a goodly number of trained instructors. This we cannot do, and because of this, and for the reasons easily deduced from the above discussion, it has been decided that it is best for our institution voluntarily to close its doors, in the interest of higher medical education."

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[1] Taken from the *Journal of the American Medical Association,* June 5, 1909.

Of course the colleges described as "commercial," "sectarian" and "low-grade" are, as a rule, the lesser known institutions. Much better conditions obtain in the average university or state school, and many are famous for their elaborate equipments, their well-attended clinics, their exceptional hospital privileges or the strength of their teaching staff. But few, unfortunately, have reason to boast of all their departments; few, in fact, are free from some glaring defect, such as Dartmouth without a dispensary, Harvard with limited hospital facilities, Syracuse lacking in obstetrical material, Arkansas "bare of equipment," Leland Stanford Junior, in a condition of disorganization and lacking hospital advantages, Kansas without a library, and so on almost to the end of the list. Perhaps a dozen institutions have in their organization, support, equipment, hospital and dispensary relations, the attainments of their instructors, and, above all, in their ideals, and the indefinable "atmosphere" that has been created, reached a plane of efficiency where true, unhampered progress may be looked for.

I emphasize ideals, since the elementary truth is often lost sight of that mere mechanical efficiency, or over-confidence in laboratory training, or chauvinism, or the worship of authority, or the arrogance born of much pedantry—any or all of these factors may utterly destroy that elusive spirit that ennobled so many in the profession in the past, and made medicine, with all its ignorance and crudities, a positive boon to mankind.

A word as to standards. Estimating our colleges at 150, we have exactly 150 standards of education. No two schools use quite the same methods or have marked out quite the same goal. This, in the abstract, is by no means a disadvantageous condition and may always be relied on to save our institutions from the paralysis of over-systematization or the deadening effect of a saturating "scientific pedantry."

But we are a long way yet from such dangers. I am indebted to Dr. Henry Beates, Jr. (of Philadelphia)[1] for one of the most startling tables that has yet been compiled. For instance, obstetrics in one college, according to Doctor Beates' investigation, requires 460 hours for its proper teaching, while another college manages to render its students proficient in 52 hours. General surgery in one college requires 2221 hours, while another college accomplishes the same task in 78 hours. In the same colleges general medicine occupies respectively over 1900 and 78 hours. Pathology in one school requires 646 hours, in another 48. Anatomy takes 1248 hours in one college, 126 in another. Physiology varies from 750 to 56 hours, the latter in no less a school than the University of Virginia. Chemistry varies from 756 to 78 hours; bacteriology from 660 to 30 hours. Neurology varies from 327 hours down to 10; dermatology and syphilis from 447 to 10; laryngorhmology, 432 to 16 hours; genito-urinary work from 480 hours to 4; medical jurisprudence from 775 hours to none!

I had intended going at much greater length into this phase of the subject, but I think enough facts have been submitted to prove to the reader that medical education is far from what it ought to be, and that the raw product of the majority of our schools is a thoroughly dangerous element. And I think the fact has been fairly demonstrated that the public, quite as much as the student, is to blame for the unfortunate but inevitable consequences of this fatal laxity of standards. Let us, therefore, try to bear this in mind while we follow the student in his early career as a practitioner.

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[1] Read at the Special Conversational Meeting of the American Academy of Medicine, Pittsburgh, January 2, 1908, and published in the Society's Bulletin for February, 1908.

I knew a young graduate who was called suddenly to attend a child in convulsions. The little one had eaten something that did not agree with it and when the young doctor arrived he found it livid, struggling violently, and quite unconscious. He thought of all he had been told to do under such circumstances and decided to give the child a hot bath. Not finding any hot water in the house, however, he procured a boiler, and filling it with lukewarm water put it on a red hot stove to heat. Up to this point he had acted very wisely, but in his inexperience he forgot that the bottom of the vessel on a hot stove may heat much more rapidly than its contents. Fearing that his little patient might die before its bath was ready, he put the unconscious form into the boiler and there held it until the water was warm enough to suit him. By this time, of course, the child had not only had a hot bath and gotten over its convulsions, but was screaming with pain. Its little legs, back and hands, pressed against the over-heated bottom, were frightfully blistered. The excited doctor, thinking only of how to cure convulsions, was actually burning the child to death. Two days later the undertaker's wagon carried away the little body.

More comic than tragic was the attempt of an over-confident young graduate of my acquaintance to remove warts from the face of a young lady, otherwise beautiful, and a recognized belle in her social set. His method, it appears, was to cut off the warts and apply a strong solution of nitrate of silver (lunar caustic).

The young surgeon, for so he accounted himself, successfully removed the warts, but, not satisfied with touching up the roots with the nitrate of silver, he painted the surrounding skin. Unfortunately he let some of the solution run down his patient's face, which necessitated vigorous swabbing, and so before he had finished he had applied his caustic remedy to the greater part of her face and neck. It was certainly a thorough job.

Next day, however, to his surprise and mortification, he was visited by an irate father and ordered to come instantly to relieve his daughter's distress. The poor girl's face, he found, had turned black and was swollen to immense proportions. An infection had likewise set in and the poor doctor awoke to the fact that his treatment for warts was not nearly so simple as he had supposed.

All ended well, however, except that the warts came back. An experienced physician was called in consultation and proper remedies applied, and so, when the danger of a malpractice suit had passed, our young surgeon found himself minus a patient, but much richer in his knowledge of nitrate of silver.

One of the first essentials to learn about the treatment of the average gunshot wound is not to probe for the bullet. Some professors, whose diplomas date from the time of the civil war, do not know of this modern discovery. On the other hand, many students who have heard the matter mentioned have mislaid their surgical notes, and, forgetting whether they were told to probe, or not to probe, have in their youthful ardor decided on prompt action. If an X-ray apparatus were lying conveniently near, their memories might be accidentally refreshed.

I was called to an urgent case one night and found a negro who had been shot and was bleeding profusely. The young physician who was treating him was much alarmed over the copious hemorrhage, which he described to the family as " subsequent hemorrhage, following shooting," whatever that might mean. The man had been shot in the calf of the leg, and as the bullet had not "come out," my friend had been called in six or seven hours later. There was no hemorrhage when he arrived; it had started after the probing. I asked him if he thought he could have injured any of the deep vessels. He replied that he " did not think so " but " was not quite sure." He seemed puzzled as to just what had happened, and did not seem to appreciate the danger of profuse bleeding, since he had almost allowed the man to die before sending for me. I succeeded in stopping the hemorrhage and left, after warning him against the dangers of infection. But this young man's watchword was " action," and he got to poulticing the wound. His patient died two weeks later; cause assigned—pneumonia!

Dr. F. H. was an over-confident young graduate with ambitions toward surgery. Almost the first case that he attempted was that of a child with tubercular glands of the neck, which he proposed to remove, using cocaine anæsthesia. This, of course, as any practitioner would have told him, is a formidable operation, owing to the network of blood-vessels and nerves found in that region.

But anatomical structures and delicate tissues were negligible quantities to H., whose only desire was to get out the " lumps." When he made the second deep incision, however, he encountered something of a surprise in the form of a miniature Niagara of blood. Thanks to his wonderful nerve and unusual good fortune, he was able to stop the hemorrhage before it was too late. Repeated injections of saline solution into the vein of the arm, and exceptionally good nursing, were instrumental in saving the little sufferer's life; but it was a long time before she recovered from the awful and unnecessary ordeal she had passed through. Seven months later her parents took her to a large city hospital where the tubercular glands were removed in approved fashion.

Such cases as these—and I could continue them indefinitely—are not necessarily examples either of insufficient college training or of culpability on the part of the student. As a matter of fact, Doctor H. comes from one of our best medical schools, and I happen to know that he was an unusually brilliant student. His education simply was not finished. He had conscientiously read his text-books, done his dissection and scanty laboratory work, taken his lectures, attended clinics, and successfully passed his examinations. He was in excellent shape—not for independent practice, but for a practical, supplementary training.

For there is no denying the fact that the young graduate begins his real education in the hospital, where he secures an interneship, or in the post-graduate schools abroad, which set him to work in the clinics and laboratories, or under an older doctor who keeps a watchful eye on his every movement. This is doing, not memorizing; gaining experience and technique, rather than cramming unintelligible formulas from quiz-compends. He is now an apprentice, applying his crude science and slowly developing his embryonic art.

But what of the host of young graduates who do not, or cannot, choose any of these paths,—the ninety per cent. or so who essay an independent practice the moment they have secured the necessary state permit? They also must acquire a practical education, and they must do it without the aid of hospitals, post-graduate schools or watchful masters. By what means and at what cost is their education completed?

To this there is but one answer; they receive their practical experiences at the expense of the community—their real education is acquired at the cost of human life. Let us glance again behind the scenes.

The young graduate, who would cheerfully operate for appendicitis or undertake a confinement case the day he has received his license, has acquired a stock of theories more or less applicable to the general practice of medicine; he has imbibed much good advice (and some bad), which he dutifully jotted down at the time, in indecipherable hieroglyphics; he has learned to take himself seriously. His ostensible mission in life is to heal the sick; but having had little or no actual training in therapeutics, and less in surgery, he naturally finds himself nonplussed by the simplest case of measles, or by a fracture of the thumb. The art of diagnosis, he discovers, is a veritable *pons asinorum*, and so he has surreptitiously to familiarize himself with a hundred diseases or ailments and a thousand conflicting symptoms, noting the results, good, bad or indifferent, of this or that remedy, and tremblingly confiding to his associates or superiors the difficulties he has encountered. All the while, perhaps for years if his preliminary education has been faulty or insufficient, he is forced to cultivate a pompous, overbearing demeanor, the better to hide his ignorance and cloak his oft-recurring blunders.

All of which is bad enough from the standpoint of his victims, but if his nature is not robust enough to withstand such corrupting influences, his whole character may be undermined. In short, a system, for which he is by no means responsible, forces him to practise chicanery and deceit, and when such practices are no longer necessary, his ideals have vanished. He then becomes selfish, arrogant, and unsympathetic; fond of subterfuge, and so skilled in the game of "bluff" that technical skill and knowledge appear of very secondary importance.

Having successfully educated himself as a general practitioner at the expense of the community, he next decides to acquire a "specialty" on the same easy terms, and so becomes a "self-acknowledged expert who has solved the difficult problem of giving nothing for something." This is the logical outcome of our present system—an unscrupulous, inefficient profession; a victimized public.

# CHAPTER IV

## THE UNSPEAKABLE QUACK

*The Criminaloid.* "By this (term) we designate such as prosper by flagitious practices which have not yet come under the effective ban of public opinion. Often, indeed, they are guilty in the eyes of the law; but since they are not culpable in the eyes of the public and in their own eyes, their spiritual attitude is not that of the criminal. The law-maker may make their misdeeds crimes, but, so long as morality stands stock-still in the old tracks, they escape both punishment and ignominy. Unlike their low-browed cousins, they occupy the cabin rather than the steerage of society. Relentless pursuit hems in the criminals, narrows their range of success, denies them influence. The *criminaloids,* on the other hand, encounter but feeble opposition, and, since their practices are often more lucrative than the authentic crimes, they distance their more scrupulous rivals in business and politics and reap an uncommon worldly prosperity."—Professor Edward Alsworth Ross, in the *Atlantic Monthly.*

As the main purpose of this book is an arraignment of the legalized abuses, if I may so word it, of the medical profession, it might seem at first thought that the advertising quacks and their methods were beneath our notice. This, however, is a mistake. Humiliating though the admission is, the fact remains that some of the most shameless of these outcasts are nevertheless legitimate practitioners of medicine. And as the law is now interpreted and enforced in most states, nine out of every ten manufacturers or vendors of patent medicines, provided these are not misbranded, are in as legitimate a business as though they were making cloth, or bread, or other necessaries of life, instead of undermining the health of the community.

The modern quack, I repeat, is too often a *bona fide* doctor; that is to say, he has graduated from some sort of a medical college and succeeded in passing a State Board examination, thereby receiving his license the same as other practitioners. But these gentry are radically different in character and temperament from the " ethical " doctor, no matter how far the latter may depart, in secret, from the high standards with which he started. For the reputable practitioner is at least governed in his outward conduct by the conventions and proprieties of the profession, whereas the quack knows no law, social or professional, and is equally ready to violate legislative enactments, provided that he can keep out of jail. He is a moral defective,—in short, a high-grade criminal who employs his medical knowledge simply and solely as a cloak for graft and imposture. That he finds a lucrative field and a never-failing mine of wealth in the complete ignorance, the morbid fears and the easy gullibility of the unsuspicious public, goes without saying.

It is a well-known but none the less curious fact that many persons of unusual intelligence—shrewd, hard-headed business men, for instance, whom ordinary sharpers would not dare to approach—will frequently " fall " for some crude and obvious imposture in the form of a patent medicine, or an " electric " belt, or a " radium " brace, or the like. And what is more, they are not open to argument in such a matter. They will show implicit faith in " testimonials," which if submitted to them in support of anything else would arouse nothing but contempt. All of which goes to support the old adage that "knowledge is power." Where we do not *know*, there is no alternative, but to *believe* or *disbelieve*, and our course is usually in the direction of our hopes and desires.

Such gullibility is next to impossible in those whose minds have had the discipline of scientific training. The ordinary untrained intellect, no matter what the degree of native common sense, does not readily appreciate the difference between authoritative knowledge and baseless assertion. The extravagant and preposterous claims made by quacks, obviously false and impossible to those who know, are more or less alluring baits to those who do not know. Instead of consulting the family physician, a man who has spent a lifetime in the management of disease, these dupes will secretly buy a wonderful new "catarrh cure," or an absurd "electric belt." Being unfamiliar with scientific thought, they are on unfamiliar ground from the start. Under the spell of a smooth-spoken quack, they will eagerly buy the gold bricks handed out to them, and clamor for more.

Even in New York, the great metropolis, such advertisements as the following are constantly appearing; and though generally suppressed and their imaginative authors frequently prosecuted, other outlandish claims just as rapidly crop out. These, of course, are old-time quacks, despite their modern nomenclature, and so render themselves liable to arrest:—

"Dr. C. Conrad, Founder, President and Medical Director of Vetus Academia Physio Medica (Inc.), Founder, President and Director-in-Chief of the Platen Institute (Inc.), Lecturer on Psychology and Physiology in the Old Physio Medical College; Founder of Osteotherapy; Demonstrator and Lecturer on Osteotherapy at Platen Institute; Founder and President of New York Society of Osteotherapeutic Physicians; Founder and Editor-in-Chief of the *Twentieth Century Journal in Osteotherapy;* Vice-President of the American Association of Physicians. Office, 56 West Sixty-fifth Street, New York, N. Y."

It is scarcely necessary to say that these institutions and societies were largely fictitious or else specially created by "Doctor" Conrad for his exclusive benefit. "Doctor" Starken's generous choice of baths also suggests a lively imagination, though the dupes who frequented his erstwhile popular establishment firmly believed in the doctor's ability to "deliver the goods." His "professional" card read as follows:

"C. F. Starken, Physician of Natural Cure and Balneo-technic, cures all kinds of Diseases without Medicine or instrument, Gives all kinds of massage and Heat Gymnastics, Magno-Electro and Hydropathic Treatments. Also all kinds of Cure-Baths, Herbs, Mineral, Sulphur, Iron, Lithion, Pine-needles, Aromatic and all Medicated baths. Specially for Blood purifying and good Complexion. Moussir, Steam, Hot Air; Vapor and Astringent Baths, For Males, Females and Children. Price Liberal. Dr. C. F. Starken, Consultation: 9-10 A. M.; 2-3 P. M. Fifty-second Street and Broadway, New York."

In Germany the public is protected by the most stringent laws against quackery, and those who attempt to circumvent the law usually land in prison. Only recently an advertising quack was sentenced to a long term of imprisonment with hard labor for "promising the impossible." Were such drastic measures taken in this country, I doubt if Sing Sing would accommodate the sudden accession to our criminal population.

In Germany, moreover, there is a wide-spread respect for authority and learning, so that the people look naturally to the medical profession to decide in such matters, and woe betide the gentleman who is officially denounced as a charlatan. In England, if the public do not pay quite so much deference to the doctors, they invariably listen to Henry Labouchère, the editor and proprietor of London *Truth*, who for a generation or more has fought and exposed every kind of fraud and humbug.

But to find the ideal remedy for quackery and its attendant evils one has to go to New Zealand, where the recent Quackery Prevention Act holds the publisher of fraudulent advertising as equally guilty with the advertiser. Clause 5 of the Act reads as follows:—

> "If any person causes any statement to be inserted in breach of this act in a newspaper printed and published in New Zealand, the printer, publisher and proprietor of that newspaper shall severally (and without excluding the liability of any other person) be deemed to have published that statement in breach of this act, and shall be liable for an offence against this act accordingly."

Of course, we have laws against fraud, which, if properly enforced, would soon clear the country of every kind of medical swindler. "Obtaining money under false pretences" is a misdemeanor at common law and by statute in nearly every state in the Union. Why, then, is the law not enforced against advertising quacks? For two reasons. First, because the American people like to be humbugged; and secondly, because the fakers have plenty of money and use it freely, both with the press and with legislators, to ensure their protection. The exhaustive exposures made by the American Medical Association and similar bodies are thus, to a large extent, ignored, and quacks continue to " promise the impossible " and acquire vast fortunes by preying upon the credulous and ignorant sick. Their license to practise is therefore made as legal as that of the decent medical practitioner. As Mr. Labouchère puts it, we authorize them to " help to fill our hospitals and cemeteries."

Nevertheless the State of New York discovered the other day that it has an old law specifically prohibiting " untrue and misleading advertisements." Assistant District Attorney Moscowitz, of New York City, who unearthed it, applied it successfully against a dealer who advertised that he had purchased several thousand raincoats at a " customs seizure " and was going to sell them at marvellously low prices. It was easily proved that no such seizure had been made, and so the astonished dealer found himself under arrest.

" Now that the ball has been set rolling," writes the editor of the *Journal of the A. M. A.*, " the possibilities of this resuscitated law seem great. For instance, the Dr. A. C. Sanden Company advertises in the New York papers the wonderful virtue of its ' health belt.' A man wearing this device ' cannot grow old; he must be young forever.' Would this come in the ' untrue and misleading ' class? In another New York paper of the same date we are told of the ' miraculous cures of cataract,' in fact, ' all eye diseases,' which the ' Magic Eye-Lotion ' brings about! Can this be ' untrue and misleading '? And, in another line of activity, we are told through a New York paper that the ' bland qualities ' of ' White Rock ' ' make high-balls harmless.' Either this is ' untrue and misleading ' or physiologic chemistry needs revising. These are but a few to start with, but the field is broad and there is no lack of material to work on."

"As one learns in detail of the methods and dangers of the modern medicine quack," writes Mr. Champe S. Andrews in the *Medical News*, [1] "there is at first a tendency to believe that the credulity of mankind is growing alarmingly greater, but a deeper study of the subject shows that the credulity upon which the charlatan relies, is the credulity that arises from weakened powers of resistance, from disordered minds, and from the mirage that such minds see mirrored in the clear sky of hope. The victim of the medical mountebank, by reason of his susceptibilities and infirmities, is in a class to himself and should have the especial care of the State."

And so he does abroad—here it is the "mountebank" who gets all the protection.

In an investigation of the psychology of quack influences, one fact is brought out with peculiar distinctness, viz., that all successful appeals to the public must be based on the skilful exaggeration of the commonplace symptoms of slight indisposition or the most trifling ailment. Certain erroneous beliefs regarding the gravity of these symptoms have consequently become firmly implanted, and when a physician contradicts them he is regarded with surprise and incredulity. The quack, on the other hand, fosters and strengthens all these delusions by every means in his power. To illustrate this I will mention a few of the most common of the exaggerated symptoms.

Pain in the back is popularly supposed to indicate kidney disease. Especially must this be so if the pain is felt in the "small of the back," a mysterious area located anywhere from the neck to the lower end of the spine. Now, as a matter of fact, the serious diseases of the kidney seldom or never give rise to pain in the back. Such pain as is commonly experienced there is almost invariably from muscular rheumatism, which is an insignificant affection and never dangerous to life. Nearly every person has, at one time or another, a touch of muscular rheumatism, or lumbago, in the back. But all have learned in a vague way of the terrors of Bright's disease, and it is an easy matter to make sick or ailing people take the most far-fetched and gloomy view of their symptoms. Indeed, when we consider how few people know anything about anatomy or physiology, it is no wonder that the quacks reap such a rich harvest by playing on their ignorant fears. When the poor dupes have been positively assured that their pains in the back are kidney pains, the deception is carried still further by an inquiry whether the patient ever has to get up in the night to urinate. He remembers, with sinking heart, that this has happened occasionally, though he forgets that at such times he probably drank an extra cup of tea or coffee for dinner. The quack shakes his head sagely and says he must analyze a specimen of the urine. This he does in the patient's presence, impressing his ignorance by a display of test tubes, burners and colored chemicals. The usual trick is to put in some diluted acid, and then add a little bicarbonate of soda. Now when these two substances are mixed together—even in clear water—they combine chemically, with an ebullition of carbonic acid gas. The trembling patient witnesses this experiment with vague terror, and begs to know what it means. Then the quack places a hand on his shoulder and says: " My friend, I will not deceive you. You are in an advanced stage of Bright's disease. It's lucky you came to me, however, for I am the only man in the city who understands kidney disease, if I do say it myself. I will guarantee to cure you in six months. If you go to any other doctor you will be dead in three months."

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[1] "Medical Quacks, their Methods and Dangers." The *Medical News*, January 7, 1905.

Pain about the region of the heart is erroneously supposed to be a symptom of heart disease, but just as pain in the back seldom or never indicates kidney trouble, so pain near the heart is scarcely ever present in organic heart disease. This pain is nearly always from the stomach, which is connected with the heart by many nerves. Thus stomach trouble, or indigestion, often reacts upon the heart and, at times, causes an irregularity in its beat. So that, owing to the great prevalence of stomach trouble in America, the quacks do a big business in " heart disease."

Another trump card for the quack to play is varicocele, which is an exceedingly common condition among men. Now small varicoceles do no harm whatever, and even larger ones, though they may cause slight discomfort, are practically harmless. Should they become troublesome they may easily be removed by a simple surgical operation—otherwise a suspensory is all that is needed. The quacks, however, make the astounding statement that varicocele is the first stage of paralysis, and that, if not treated early, and by their particular method, the patient is doomed. A little knowledge of anatomy and physiology would show any man what a varicocele is and how it is formed, and such knowledge would also convince him of the absolute falsity of the quack's statement that varicocele could have any causative influence in paralysis.

Catarrh is yet another of the quack's great strongholds, and for the same reason as the foregoing, namely, that it is a very common complaint. But, while it is an annoying affection, it is not in the least dangerous, although it is usually chronic in its course and difficult to get entirely rid of, hence being an ideal complaint for the quack's purpose. What more easy than to inform a patient that his catarrh will surely lead to consumption, cancer or glanders? The alarmed but unsuspecting dupe accordingly pays down a sum of money and starts in with a formidable course of treatment, which lasts just as long as his money and patience hold out.

But perhaps the frauds that pay best of all are those based upon venereal diseases, real and imaginary. The scoundrels in this case usually resort to small pamphlets, purporting to set forth the evils and horrors of "lost manhood," self-abuse, impotence and sterility. This lurid and misleading literature is put in the hands of youths and even boys. Men are often paid to stand on corners near to schools and other institutions to hand pamphlets to the boys as they come and go. It is a great pity that so much ignorance prevails among young people in regard to matters of sex, and that parents are so backward and diffident about mentioning them to their children. If such instruction were the rule, instead of the exception, boys and girls would be forewarned and forearmed against the real danger—the danger that lies in ignorance. The result is usually a morbid curiosity to learn more of this subject about which there is so much mystery. Such curiosity is always satisfied in time, but secretly, and often through the vilest of companions and associations.

The flaming literature of the quack at once arrests the attention of young men in this state of mind. The pamphlets are worded with diabolical art and cunning. The most ordinary and commonplace conditions are twisted into pathological symptoms. By the time a poor youth has perused the tissue of lies he is about convinced that he must be somehow a victim of venereal disease, even though he may never have been actually exposed to it. And if, in addition, he happens to have varicocele, he sees no future but that of an incurable paralytic. But at last a ray of hope illumines his darkened soul. The final paragraph states that the writer—this altruistic being who consents to practise medicine solely in the interests of humanity—has discovered the sovereign remedy. The victims of " youthful errors " and " lost manhood " may rely on him and him alone to save them.

" Young men! Come to me, if you would be saved from the errors of youth!" Some such legend is conspicuous in nearly every public toilet, a bait for the ignorant and unwary.

But thousands of grown men, who ought to have better sense, patronize these charlatans for treatment of venereal diseases. And here is where one of the worst and most far-reaching evils occurs. A man engaged to be married has contracted venereal disease. He may have acquired it during the jovial, alcoholic wind-up of a stag party, or perhaps his moral standard is so low that he does not consider his engagement as binding him to shun vicious associations. In any case he is now badly frightened, and in desperate haste to get cured before the wedding day arrives. If sense has conquered shame he consults his family physician, and the latter strongly advises him to postpone his marriage indefinitely. For it takes not less than three years to cure syphilis, and at least six months to eradicate gonorrhœa. Just at this time, however, our Lothario reads a quack pamphlet. Ah, this is just what he wants! "All venereal diseases cured to stay cured after a few weeks' (or days') treatment." So he rushes off to the "specialist," and puts himself in his hands. In a brief time, as the latter promised, the symptoms have subsided or become obscured, and the marriage consequently takes place. A little later, however, the innocent wife is a victim of the loathsome venereal disease of which her husband thought the quack had cured him.

The power and influence of the advertising quacks depends largely upon the complete ignorance of the general public in regard to all matters medical, anatomical and physiological. Very few people know where the liver is. Several times, while treating patients for obscure or doubtful cases of a certain disease, I have been seriously asked: "Doctor, if I really haven't this disease, isn't there danger that your medicine might give it to me?" Absurd as is such a question, the enquirers have not always been fools. That it *could* be asked at all, and by persons otherwise intelligent, is a significant fact, and one that goes a long way toward accounting for the widespread and pernicious influence of the quacks.

No better illustration of this appalling ignorance, coupled with complete credulity, could be found than the two pathetic cases given by Dr. J. E. Miller (of Rogersville, Tennessee) in the *Journal of The American Med-*

*ical Association* of May 11, 1907. Undoubtedly hundreds of thousands of such cases would be unearthed were a systematic investigation made by the federal or the various state authorities.

"Case 1. In the latter part of May, 1906, I was sent for to amputate the breast of Mrs. M. T., aged about 55, who resided in this town. I found her in great agony. A cake of absorbent cotton covered the entire left breast, arm, side and back, down to the crest of the ilium. About three months prior to this time she had discovered a small, freely movable tumor about the size of a robin's egg in the left breast; it was not attended with pain or any discomfort. She became somewhat alarmed, and her sister, with whom she lived, found an advertisement in their religious paper of 'Dr.' D. M. Bye and his 'Wonderful Oil Cure for Cancer.' For many weeks prior to the time I saw her she had been using the 'oil cure' with the result that all the skin and part of the flesh was burned off from the extensive region covered by the absorbent cotton, which had become converted into an extensive scab. (I see from one of his letters to her that the application of cotton was directed, and that in her case the 'oil' had been somewhat modified, making it stronger.) The condition was septic in the highest degree, suppuration and absorption going on beneath the cake of cotton. I was able to remove the 'dressing' by insinuating peroxide of hydrogen beneath it, the whole coming off in one solid mass. The wound had the appearance of a deep-seated burn. The lump in the breast, I was informed, had undergone no perceptible change. The woman was in a pitiable condition and no operation was considered. She died from sepsis and exhaustion in two days after coming under my observation.

"The little tumor, while probably malignant, was not a factor in her taking off, but death, in my opinion, was directly due to the corrosive applications made by direction of 'Dr.' Bye. It appeared that she had paid the Bye concern $500 and at the time of her death a box of the 'treatment' arrived at the express office, for which $50 had been paid. The Bye concern refused to take it back or to allow the sister anything whatever for it, although they had guaranteed a cure. Removal of the growth was the only treatment that should have been considered in this case."

"Case 2. Mrs. B., a widow, with several small children, totally blind from glaucoma, had been told by myself and other physicians that nothing whatever could be done to restore or in any manner to benefit her sight. She was written to by 'Dr. Coffee, Eye Specialist,' who, without the least idea of the nature of her trouble, undertook to guarantee a perfect cure. The woman was very poor, but she managed to pay him $8 a month for more than two years. When she could no longer raise the necessary amount, he reduced the fee to $5 and this payment was kept up for many months, until it became utterly impossible for her to pay him anything whatever. He used the 'absorption' method. His letters to this woman are before me, and are cunning and ingenious. They explain in a graphic manner that a 'membrain' has formed over the sight, and just as soon as his medicine 'absorbs' the growth, her vision will be as good as ever; that 'vision would not return as long as there was a vestige of membrain,' that the 'membrain was growing thinner all the time,' and that it would return very suddenly, and that it would be disastrous to give up treatment, that maybe one more application of his absorbent would have been sufficient."

As the reader is no doubt aware, two prominent periodicals—*Collier's Weekly* and the *Ladies' Home*

*Journal*—have fearlessly exposed the quack and his methods, and in so thorough and energetic a manner that incalculable good has been done. Names and photographs were freely used, and so carefully were the proofs collected that suit was brought in only one or two instances. Mr. Samuel Hopkins Adams' series on "The Great American Fraud," which ran in *Collier's*, has since appeared in pamphlet form and has been largely distributed by the American Medical Association.

Mr. Adams investigated every phase of the subject with a completeness and vigor that leaves nothing to be desired. Several of the leading quacks, knowing they were in for an exposure, wrote begging him to pass them with his big stick. But Adams, following the excellent example of Labouchère, spared none.

Some of the most hideous schemes that he discovered were the so-called "cures" for drug habits. These "cures" were analyzed by expert chemists and found to contain large doses of morphine and cocaine. Another piece of deviltry was the "nasal catarrh spray," which also contained cocaine. Use of this for a short time almost invariably develops the frightful cocaine habit. This was the deliberate purpose of the quack, so that the victim would buy more and more of his "dope." Mr. Adams investigated a large number of the "testimonials" as to the wonderful cures wrought by this and that quack or patent medicine, and in every case he found them spurious. Either they were paid for in cold cash, or else the testifiers were brought to admit that they lent their names and photographs because of the satisfaction derived from seeing themselves in print.

The two influential publications above mentioned, and many other prominent monthlies and weeklies, have long since dropped all patent medicine advertising even to hair tonics and medicated soaps. The city dailies, the country weeklies, and especially the religious journals, are now the worst sinners in this respect, but it will be only a question of time till public opinion will demand as high a standard in the advertising columns of the press as in the body of the publication. When the privilege of advertising is denied to medical fakes, Uncle Sam will surely be shamed into denying them the use of the mails, either for circularizing the public, for receiving money, or for shipping their medicines, and when that auspicious day arrives, the unspeakable quack will have sunk into comparative harmlessness. In another generation, I venture to assert, a gentleman following this nefarious calling will be quite as much of a curiosity as a savage wolf at large. Both wolf and quack, unless I am greatly mistaken, would find themselves promptly placed behind bars.

But we must not overlook one great legislative victory that has already been won. I refer to the Federal Pure Food Law which went into effect January 1, 1906, and has unquestionably protected the public from many of the grosser frauds that were so shamelessly practised not only in the mishandling of drugs but in the drugging or adulterating of foods and liquors. The first case brought into court was that of Robert W. Harper, of Washington, D. C., a bank president and capitalist, but also proprietor of Harper's "Cuforhedake Branefude," which, although extensiely advertised as harmless, was found to contain the following ingredients:

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|---|---|
| Alcohol (per cent. by volume) | 24.2 |
| Acetanilid (grains per ounce) | 15.0 |
| Caffein (per cent.) | 1.5 |
| Antipyrin (per cent.) | 1.0 |

Potassium, sodium and bromides also present.

Mr. Harper, as may be remembered, was fined $700, and narrowly escaped going to jail, whereupon many patent medicine manufacturers and advertising quacks decided to change their calling. Just why a man may be punished for misbranding a preparation and yet allowed to tell the most preposterous falsehoods about its curative properties or about his own skill in medicine is, of course, not very clear. Nevertheless an excellent start has been made, and all who desire to see the suppression of quackery in all forms should take courage.

In the meantime it behooves the regular practitioner not only to expose and condemn the practices of these swindlers, but to assure himself that he has been in no wise to blame for the deplorable evil. For, as Dr. John B. Roberts (of Philadelphia) remarks,[1] "the sick often seek the advertising doctor, and believe the false assertions of the patent medicine label because they have found the medical men known to them to be incapable, inefficient or so exorbitant in fees that help seems impossible at their hands."

"The family," adds Roberts, "which can obtain efficient medical aid for a moderate fee near its home does not often drift into the hands of the recognized quacks."

[1] At the regular meeting of the Medical Jurisprudence Society, Philadelphia, March 19, 1906. As reported in the *Journal of the American Medical Association,* April 21, 1910.

# CHAPTER V

## VIVISECTION—STRAINING AT THE GNAT

"So long as civilization exacts pain and toil, suffering and death of the lower animals, not only for commercial and industrial reasons, but in many cases simply for the gratification of vanity or the indulgence of luxurious tastes, so long will the reformer, desiring to alleviate animal pain, find an ample field for the exercise of his well-meant efforts, without ignorantly interfering in the most altruistic of all scientific movements, viz., the prevention and cure of the diseases to which mankind has long been heir."—From an editorial in the *Journal of the American Medical Association.*

Perhaps no subject pertaining to medicine has received so much public attention and been discussed so heatedly as vivisection. Certainly no subject has inspired such positive and conflicting opinions from lay writers. That one side must be largely in the wrong, either in its facts, or in the deductions based upon these alleged facts, goes without saying. In the following pages I propose to show how woefully misinformed the public has been on this matter, and how severe a blow would be dealt to science and universal progress were vivisection prohibited by law. I refer, of course, to animal vivisection—human vivisection will be taken up in succeeding chapters.

Vivisection, to the general laity, means the dissection of living animals without the employment of anæsthetics, ostensibly for the advancement of science—in reality to gratify a lust for cruelty. There can be no doubt, after reading at random in the newspapers and magazines, that this is the popular conception. So, naturally and to the great credit of human nature, the belief that such diabolical cruelty is rife among surgeons and biologists arouses extreme indignation, and a desire for legislation that will punish the offenders and protect the dumb sufferers from future outrage.

But this idea is in most cases entirely erroneous, that is, so far as it relates to reputable surgeons and medical instructors, and were there any truth in it none would be quicker than they to raise a voice of protest. Surely their scathing denunciation of the real evils that have crept into the profession is sufficient proof that the charges of the antivivisectionists are largely fiction. Public opinion is not only unfair, but displays weak judgment when it classes these benefactors of the race with heartless students and degenerates who have been found guilty of torturing animals for the mere enjoyment of their suffering. And in striving to place a ban upon all animal experimentation, they would cripple the humanitarian labors of the most disinterested men of science while virtually encouraging that selfish indifference to human life that so alarmingly pervades our ranks. As the St. Louis *Republican* said of the proposed antivivisection law in Missouri: "It might fitly be called an act to substitute children and their parents for dogs, cats and mice in surgical experiments."

The true facts of scientific vivisection are these:

When, in the interests of human life and health, it becomes desirable to ascertain, if possible, certain physiologic, pathologic or chemical processes, a suitable animal is chloroformed, or otherwise rendered unconscious or insensible to pain, and then such section is performed, or such drugs introduced into the circulation, as is necessary for the demonstration.

There was a time, not many decades ago, when vivisection could be performed only on the quivering flesh of conscious animals, no matter how keen the repugnance of the experimenter to the suffering that he caused. That time of horror was prior to the use of anæsthetics in 1846. Then the most exquisitely painful surgical operations had to be performed without regard to the agony of the patient, whose body was usually bound to the operating table. The sufferer might hope for no relief during the terrible ordeal save when the torture became so excruciating that nature granted a blissful though brief unconsciousness. And following the operation came a long and tedious recovery, with inevitable infection of the wound by pus, and the added pain and suffering and blood poisoning caused largely by the surgeon's hands, which his limited knowledge had not taught him to disinfect.

Now all this is changed. Chemistry has given us anæsthetics, and bacteriology has shown the surgeon how to prevent pus infection—two magnificent results. But to what do we owe our present knowledge of the properties of chloroform and other anæsthetics, and of the science underlying clean surgery? To animal experimentation almost entirely. This is a matter of sober fact, and those who deny it merely display their ignorance of the history of scientific progress in surgery. Chloroform used ignorantly is an agent very dangerous to life. Before Sir James Simpson introduced it into surgical practice he tested its effects upon animals. Many animals were killed in these experiments, but Sir James thereby learned its properties, its virtues and its dangers. Had he not used the animals for this purpose, several human lives would have necessarily been sacrificed and very possibly the fear excited by the first failures would have prevented further experiments with so dangerous a substance.

Was this grand result dearly bought, or wrongly bought, at the sacrifice of the lives of a few lower animals? Those antivivisectionists who have never had to endure a surgical operation may say yes. Those who have been through the ordeal, or seen a loved one under the knife, will pause and think before they condemn a knowledge so acquired, which has spared themselves and others the unspeakable anguish that our forefathers were forced to endure.

Then as to clean modern surgery. Formerly it was the rule to have protracted and painful healing of wounds. Nowadays this is the exception. Why? Because wound infection has been studied scientifically. Its causes are understood and every modern surgeon knows how it may be avoided. In the old days, before Lord Lister's time, wound infection was so common as to be nearly invariable, and when, in very rare cases, it did not occur, the phenomenon was regarded with wonder and even suspicion. This gave rise to a gross surgical misconception. The formation of pus was actually hailed as a favorable sign, and hence came the absurd misnomer "laudable pus." We of to-day know that pus, far from being laudable, is the surgical result of all others to be feared, being the actual cause of peritonitis, blood-poisoning, deformity, suffering and death. Furthermore, the occurrence of pus in a supposed surgically clean wound is generally a serious reflection on the technique and ability of the surgeon.

All must admit that this knowledge of antiseptics and aseptics is an immense boon to humanity. It would seem that almost any sacrifice would have been justifiable, or at least excusable, to secure this end. And how was this knowledge arrived at? By experiments on animals: in no other way could it have been gained, except by actual experiment on human beings. Are the lives of a few dogs, rabbits and guinea-pigs, then, to be put in the balance against the present and future welfare of humanity?

The endeavor to improve the condition of domestic animals is certainly laudable. No one is fonder of horses and dogs than is the writer of this book, and none could feel greater resentment towards those who ill-treat them. According to the religious systems of the East, humanity owes to the animal kingdom a certain responsibility which, in the case of the higher domestic animals, is supposed to be essential to their further evolution. This is a beautiful idea, being, in fact, the spiritual concomitant of the Darwinian theory of physical evolution.

But there is a moral danger in these humane movements in the interests of the "lesser children" of nature. It is an obvious fact that those who are prominent in such societies are liable to become abnormally interested in animal welfare and comfort. There is a strong tendency to exaggerate the importance and sensibility of the lower animals both in nature and in their relation to mankind. And with this abnormal interest in animals there appears, not uncommonly, a corresponding indifference to, or even dislike of, children. This attitude is not by any means confined to members of humane societies. In the high and fast society of the mentally resourceless rich it is the rule for young married women to display absurd affection for pet dogs, and to refuse to become mothers. Often we see such women lavish affection—or what resembles it—on a hideous pug dog one moment, and in the next repulse an attractive child. Indeed it is the cult of the dog, as the *British Medical Journal* points out, that leads the antivivisectionists into some of their most remarkable aberrations, so that the preposterous yarns that have been spread throughout the United Kingdom, like the most effective pictures, nearly all relate to legendary canines.

An amusing though typical case was brought up in the House of Commons recently when Mr. Ellis Griffith asked the Home Secretary whether his attention had been called to a public experiment performed on a bull-dog by Doctor Waller. He described to the horror of his listeners how a leather strap with sharp nails was secured around the meek animal's neck while his feet were immersed in glass jars containing salts in solution and the jars were connected by wires with galvanometers. Mr. Gladstone explained that this dreadful experiment consisted in making the dog stand for a time in water in which common salt had been added. "If," continued the Home Secretary, "my honorable friend has ever paddled in the sea he will understand the sensation. The animal —a finely developed bull-dog—was neither tied nor muzzled. He wore a leather collar ornamented with brass studs. Had the experiment been painful the pain no doubt would have been immediately felt by those near the dog. There was no sign of this." Mr. Gladstone, therefore, did not take any action.[1]

This grotesque example—and similar cases could be multiplied—shows to what inhuman lengths such misplaced sentimentality can be carried. I say inhuman, for can a man claim a well-balanced mind and a normal love of his species, who, in the face of the alarming spread of poverty, pauperism and physical deterioration that British statesmen and sociologists alike admit and deplore, would attempt to direct the attention of the nation to the alleged discomfort of a robust, well-fed bull-dog?

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[1] As reported in the *British Medical Journal,* July 17, 1909.

" They are not to be laughed out of court," says *Collier's Weekly*, " these crusaders in a mistaken cause, for their contention of unselfish and ennobling principles. But their apparent humanitarianism is fallacious. Intended to reduce the sum of animal suffering in the immediate sense, it (the proposed New York State law) would in the end immeasurably retard the work of alleviating human pain and saving human lives." And in another editorial: " No more weak and foolish agitation has been started than this attack on medical progress for the sake of the ' poor defenceless dog.' There is enough wanton cruelty in this world, whether to animals, or to children, women and men. Let our sensational newspapers, let excited friends busy themselves with the millions who are needlessly in pain and keep their hands off that profession which is doing most to lessen the suffering of this world. A law opposed by all competent doctors in the world is a foolish and harmful law to pass."

" They are queer people—the antivivisectionists,"—remarks the New York *Times*, editorially: " Unhappy victims of what Doctor Dana called the zoophil-neurosis, their love of animals seems to involve an actual hatred of human beings. The sight of a child dying of diphtheria or spinal meningitis leaves them cold, but the killing of the chloroformed guinea-pig throws them into hysterics of indignation."

But the antivivisectionists are not consistent even in their defence of animals. What do we hear of the bleeding of calves to produce " white " veal; of the rough and unsanitary castration of animals from which painful and unnecessary wounds often ensue; what of the plucking of live fowls, the clipping of dogs' ears, the branding of cattle, the fisherman's amiable disregard of the struggling victims of his sport? And how shall we explain the indifferent attitude of the antivivisectionists and other animal champions toward the slaughter of animals for food? Surely if human health and life itself must not weigh against the discomfort or premature death of a few small animals, no amount of mere gratification of the palate should sanction the ruthless slaughter of the millions of cattle, sheep and hogs which our modern civilization so complacently sanctions.[1]

I have mentioned angling, but what of the wholesale and heartless destruction of animal and bird life that passes muster under the name of sport? Think of the countless birds and deer and fur-bearing animals that are ruthlessly killed and mutilated every year. Women who are really sincere in their love of animals do not need these feathers and fur trimmings on their hats. Epicures may desire venison, but they can get along without it.

Then again, why do we not hear more about the animal traps used by farmers and hunters? Thousands—hundreds of thousands—of rabbits, ground hogs, minks, raccoons, skunks, etc., are annually caught in these traps, and, as a rule, are forced to suffer for long periods before the trapper arrives to put them out of misery and appropriate the torn and bloody pelt.

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[1] According to Dr. Charles W. Eliot there are slaughtered every year in the United States more than 50,000,000 beeves, sheep and hogs, and 250,000,000 chickens, turkeys and geese. Last year more than 360,000 dogs and cats were killed in a single year in twenty of the largest cities of the country merely to remove stray animals from the streets. In New York City alone during the past fourteen years more than 800,000 cats and 400,000 dogs have thus been destroyed.

All this suffering, whether necessary or wholly preventable, inspires practically no murmur of disapproval; the antivivisectionist scarcely knows of its existence. But when a man of science, trained in the use of anæsthetics (and it is animals, strange to say, rather than men that get the services of the expert in anæsthesia), operates for the benefit of humanity on an insensible rabbit, a cry goes up that fairly rends the heavens. Listen to the sentiments of two leading crusaders upon the achievements of Pasteur:—

Mrs. Diana Belais (of New York) in a recent pamphlet: " Pasteur and his followers increased a very rare disease called rabies, and are making fortunes out of the antirabic virus." Which the *Sun*, slightly out of temper, styles " an infamous and malicious lie."

Mrs. Liza H. Badger, Secretary of the New York Anti-Vivisection Society, in a letter to the *Sun*, February 22, 1909: " I repeat that Pasteur was not only a murderer but a charlatan and a plagiarist, and we can prove it. . . . Boston, which ' knows it all,' has an 'Avenue Pasteur.' The world moves! We may yet outdo Boston and have an Avenue ' Jack-the-Ripper ' in New York." " We maintain," retorts the *Sun*, " that it is a disgusting spectacle to see so great a benefactor as Pasteur treated in this frivolous manner by a parcel of unscrupulous women."

Before enumerating the results of vivisection, I must concede that there are certain regrettable conditions which furnish ammunition to these belligerent extremists, and which a majority of the leading experimentalists, I am glad to say, regard as unjustifiable. One is the ordinary routine demonstration made in physiological laboratories merely for the purpose of showing to students the action of the heart, lungs, and so forth. I am unable to see where any great benefit results from such demonstrations, and there is the ever-present danger of arousing inhuman and perverted instincts in the spectators. Furthermore, I believe all reputable surgeons who encourage the practice among their students of operating upon anæsthetized animals will welcome the day when medicine and surgery will have become, as abroad, two distinct professions. Then, of course, the embryo doctor will have no business in the class of surgical experimentation and much useless, though probably well-intentioned, mutilation of animals will have been abolished. But till that time arrives the *system,* not the surgeon or the pathological demonstrator, must be blamed, since the professor has no idea which of his students are eventually to become surgeons, and neither in many cases have the students themselves.

Another condition I have in mind is where certain French and German psychologists have experimented on unanæsthetized animals for the purpose of studying the emotions under torture. The results obtained from such sources may be, in many instances, highly interesting, but their practical application to human welfare and happiness is at present too abstract or indefinite to justify the means employed. Personally I should be glad to see these two classes of animal experimentation forbidden.

I regret to see that several eminent experimentalists in this country have been led into certain of these bypaths of science, among whom is Dr. George W. Crile of Cleveland. Now Dr. Crile is an authority on shock, and the study of shock is of inestimable value in the development of surgery, yet one wonders if his enthusiasm did not get the better of his discretion when he performed the following experiment which he recently reported:—

> " In a further effort to produce shock, the right hind paw was deeply burned. The left hind paw was burned. The right sciatic nerve was exposed, with some hemorrhage occurring during the operation. Peripheral and central traction was exerted and torsion, and the nerve was rubbed so much that it finally was rubbed through. The only effect was to increase the respiratory rate."

In any case he has managed to secure an immense amount of undesirable publicity, and has to that extent endangered the practice of the more essential and certainly less gruesome experiments upon animals that are carried on in the ordinary laboratory.

Let us now hastily survey the actual, tangible results of animal vivisection that have come to medicine and surgery, and hence that make for progress and the greater welfare of mankind.

Cocaine as a local anæsthetic and in eye surgery is unrivalled. But it is a powerful and very dangerous drug in ignorant hands. Had it not been first tried on animals many human lives would have been lost before its properties would have been understood sufficiently to make its use at all reliable.

Digitalis is one of our most valuable heart stimulants and tonics. Doctor Senn's experiments are classic, and the thesis in which they were described won for him the degree of Doctor of Philosophy.

Surgery of the intestines became possible to surgeons in general after the experiments of Parkes, Senn, and others, with animals.

The spleen, stomach and gall-bladder have been removed when diseased or injured to an extent fatal to life had they been left in the body. Animal experimentation made this possible.

Laparotomy, or opening the abdomen, thanks to animal experimentation, is now a recognized surgical procedure when an accurate diagnosis cannot be made otherwise. Performed by a skilled surgeon the operation is only slightly dangerous in itself, while formerly the mortality from peritonitis made this one of the worst scourges of mankind.

Sunstroke is now better understood and more lives can be saved as the result of Dr. H. C. Wood's experiments.

Diphtheria has always been one of the most fatal and dreaded of diseases. It is still dangerous, but since the discovery of anti-toxin by Behring and Roux the mortality has declined marvellously.

Bubonic plague, the terror of the past, is to-day pretty well understood. Its mode of spreading by rats and fleas having been worked out by the exhaustive experiments of the British Plague Commission of India has made it possible to institute appropriate quarantine measures. Witness how the last plague invasion of San Francisco was stamped out.

When experiment demonstrated that animals could live after removal of one kidney, it become possible to save the lives of many persons afflicted with tuberculosis or other fatal diseases of one kidney by its total extirpation.

Modern brain surgery is one of our most brilliant achievements. Many who would formerly have had to die of depressed fractures of the skull or brain tumors can now be saved because by experiments on the brains of living animals we have ascertained the principal functions of nearly every cubic inch of the brain tissue and the symptoms following injury or disease of any particular area.

Smallpox, formerly one of the most loathsome and fatal diseases, has dwindled into comparative insignificance. This is the direct result of vaccination, which is effected through animal agency.

Hydrophobia used to occur in about sixteen per cent. of persons bitten by mad dogs. The mortality was one hundred per cent., the disease being absolutely fatal. Since the employment of the Pasteur method the mortality in cases bitten has fallen from sixteen to less than one per cent. There is reason to hope that further experiments will finally result in a serum that will cure the disease after it has actually appeared.

We seem to be on the eve of wonderful discoveries in regard to the cause and treatment of cancer. Animal experimentation has led us up to this point. If antivivisection laws are enacted the cancer work in this country will have to stop where it is, and the multitude of victims of this dreaded disease must abandon the hope that now makes their wretched lives barely tolerable.

I could go on indefinitely in this vein, but will only refer to one more instance of benefit resulting from animal experimentation, and that is to animals themselves. Formerly, in Europe, thousands of cattle and hogs were carried off yearly by anthrax, swine plague, etc. Pasteur studied these diseases and discovered vaccination processes which protected the herds from these former scourges.

For many years past the laws of Great Britain have practically prohibited vivisection. The result is that surgery in England is far behind surgery in other countries. When Lord Lister was engaged in the epoch-making series of experiments that gave to the world the knowledge that has made all of our great modern surgery possible, the short-sighted, sentimental laws of his own country obliged him to go to France to complete his work.

In America, strenuous efforts are being made by ill-advised persons and societies to have enacted antivivisection laws of a similar drastic character. Instead of confining themselves to the questionable experiments of faddists and perverts, and to the fruitless attempts of amateurs, usually students, to ape the ultra scientific achievements of such experimenters, they attack the legitimate work of our greatest schools and institutes, and clamor for the practical annihilation of this supremely important branch of medical research. They confront the whole mass of scientific demonstration with the bold statement of some obscure practitioner, notoriety-loving "reformer," or hysterical layman, and work on public sympathy by printing maudlin pictures, such as an old blind beggar being led about the streets by a dog, with the irrelevant legend, "A friend in need." All of which is flimsy sophistry and sentimentality, and inspires nothing but contempt or amusement in those who know. For it must be fully understood that this agitation is intended to appeal to the ignorant and ill-informed. As the agitators in England frankly avow "the movement must be democratized." Democratized science!

If these ignorant meddlers succeed in having such antivivisection laws passed in the United States, it will be a matter of extreme regret on the part of the truly humane. Surgical progress will come to a standstill. Now we are in many respects in the lead, but in that event we shall have the mortification of seeing Germany and France, and in time every other country in Europe, surpass us. Surely the antivivisectionist might find a nobler task than blindly to attack one of the most fruitful fields in all modern science.

Concluding his memorable address delivered at the Massachusetts General Hospital, Boston, on the 63rd anniversary of Ether Day, October 16, 1909, Dr. Charles W. Eliot, President Emeritus of Harvard University, said:—

> "If the educated public could only see clearly the immense benefits to mankind which have already come and may reasonably be expected to come in much larger amount from the experiments on animals which are necessary to the progress of medical research, if the public could only clearly realize the saving of human suffering and woe which has already resulted and is sure to result in still greater proportion from the sacrifice of a very limited amount of animal comfort and joy, the world would hear nothing more of objections to medical research. The most tender-hearted human being is ordinarily unable to fix a limit to the number of inferior animals he would sacrifice to save the life of one human baby. Now a baby is itself only a hope or a potentiality, its present power of enjoyment being extremely limited. What mother could fix a limit to the number of times a comfortable horse should be bled moderately,

or to the number of guinea pigs which should be sacrificed, in order to save her baby attacked by diphtheria? The tender-hearted men and women who object to animal experimentation have no vision of the relief of human beings from agony and woe which has come out of animal experimentation. If they had any such vision, they would themselves manifest extraordinary cruelty and inhumanity in opposing medical research; in their present blindness they attribute delight in inflicting suffering to the patient, far-seeing and far-hoping seekers for biological truth. Which is the truly humane and merciful man, the director of the Rockefeller Institute for Medical Research, who, by producing cerebrospinal meningitis in a few monkeys lately succeeded in providing men with a successful mode of treating that formidable disease, or the lawyer or newspaper writer who endeavored to prevent those experiments on monkeys, and is ready to let the human race remain helpless on the occasional visitations of that heretofore fatal disease? Humanity and mercy are conspicuously the attributes of medical research in the eyes of all people who can see what it has already done and what it promises to do."

In conclusion let it be remembered that the whole popular conception of animal vivisection is a gross exaggeration and distortion of the real facts. The word has become a misnomer and serves no other purpose than to call up distressing hallucinations and phantasms, and to influence public opinion against an imaginary evil. The antivivisectionist and his sympathizers are one and all straining at a gnat—how willingly and uncomplainingly they swallow the camel, human vivisection, will be shown in the next chapter.

# CHAPTER VI

## VIVISECTION—SWALLOWING THE CAMEL

"Oh, that men would stoop to learn, or at least cease to destroy!"—Stokes.

"We regard those as surgeons, and those alone, who have, by conscientious devotion to the study of our science and the daily habitual discharge of its multifarious duties, acquired that knowledge which renders the mind of the practitioner serene, his judgment sound, and hands skilful, while it holds out to the patient rational hopes of amended health and prolonged life."—Dr. Valentine Mott.

It is sometimes necessary in making up one's mind on an important issue to consider causes as well as resultant conditions. It is un-American, I admit, to grope around beneath the surface of things, and we generally come up gasping, yet the exercise is by no means harmful. Let me invite the reader to join me now in a brief excursion.

The reason that animal vivisection is, on the whole, free from the abuses which an ill-informed but imaginative public have conjured up is that it is not a paying branch of medicine. Rabbits and cats do not pay to have their kidneys removed, nor do they testify to the marvellous manner in which they were rescued from the jaws of death. The man who patiently devotes years of his life to original research receives, at best, the meagre salary of a professorship in some college, while if he is a practising physician or surgeon he loses rather than gains by his devotion to science. Even honors are few and far between, so that his research is, in nine cases out of ten, a pure labor of love. Such unselfish devotion does not ordinarily foster inhumanity;

on the contrary, these men, as a rule, are among the noblest in the profession, and deserve unstinted praise for their tolerant attitude toward their hysterical detractors.

The practice of surgery, on the other hand, is becoming lucrative. The fee charged for an operation on a wealthy patient is often enormous, and the most trifling ailment, if it calls for surgical intervention, costs the patient as much as weeks of treatment under a regular practitioner.

Now far be it from me to underrate the services of the skilled surgeon, or to say that a man of means should not pay handsomely for a necessary operation. I simply desire to show how existing conditions must naturally lead to unnecessary or fraudulent surgery, and to much incompetent surgery, whether fraudulent or not, at the hands of over-confident operators. There is no motive, except in the case of perverts, for the unnecessary mutilation of animals, but the doctor of ordinary ambition and easy conscience has every incentive to operate on his patient. In the first place, he gains practice thereby; in the second place, he gets paid for his work; and lastly, incredible as it may seem, whereas the mutilation or killing of animals brings disrepute, and is apt to be investigated by the public, the mutilation or killing of a human being ordinarily brings no disgrace, is not even investigated, and frequently means a substantial fee to the dishonest or incompetent operator. Here then lies the cause of the surgical outrages that I shall lay bare in this and the following chapters,—our "rotten system."[1]

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[1] I am borrowing the expression from Dr. Graham Lusk. "The truth is," says Doctor Lusk, "that the whole system is rotten and

It was Bernard Shaw, I believe, who brought down the wrath of British surgeons by remarking that when it was a question of earning sixty guineas in an afternoon, it was a very strong temptation to a man who could do that by performing an operation to believe that an operation was necessary when it was not necessary. He did not think it was good public policy for any person to have a strong pecuniary interest in mutilating his fellows.

"It is one thing to make an honest search for the truth," writes Dr. G. H. Balleray (of Paterson, New Jersey) to the *Medical Record*,[1] "in the interests of the patient, and quite another to play the charlatan while pretending to base one's practice upon scientific accuracy." Continuing, he says:—

> "With some practitioners every belly ache is called appendicitis, and an operation for the removal of a normal appendix follows forthwith. The writer has seen the appendix removed in a number of cases in which it was absolutely normal, and within the past five years he has been consulted by many women who had been told that they should submit to an operation for what was said to be appendicitis, but the subsequent history showed that no operation was necessary in most of the cases; and in those in which abdominal section was necessary it was found that the appendix had nothing to do with the symptoms complained of. In times gone by, when a physician was too indolent or too ignorant to make a diagnosis, he labelled the disease 'malaria,' and

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reeking, and cries out for drastic reformation."—"Medical Education," in the *Journal of the American Medical Association*, April 17, 1909.

[1] The *Medical Record*, February 9, 1907. Doctor Balleray's letter is quoted in full in Appendix B.

everybody was satisfied. Now the so-called surgeon calls everything appendicitis, and cuts out the appendix, with equally gratifying results. The furor for unnecessary operations has spread to the laity, and the cheerfulness with which the would-be fashionable man parts with his appendix is only equalled by the *abandon* with which the modern woman submits to the evisceration of her pelvis by her pet gynecologist. Practising fantastic operations on the kidney keeps some men in the profession busy. A poor, thin, neurotic woman, whose circumrenal fat has been absorbed, leaving the kidney anchored only by its moorings, consults one of these men. With wonderful sagacity he diagnoses 'floating kidney' and at once performs nephrorrhaphy. If from rest in bed and general improvement in health therefrom a layer of fat is deposited around the kidney the woman is cured, and the doctor gives the credit to the operation."

Writing in the *Journal of the American Medical Association* upon "Conservatism in Surgery,"[1] Professor James E. Moore (of Minneapolis) has something to say on "radicalism" as well. To wit:—

"If from a surgical standpoint we thus condemn the conservative for his sins of omission, how much more must we condemn the radical for his sins of commission; for the former is not a surgeon in the common acceptance of the term, while the latter is classed as one because he is constantly performing operations. The radical is one who believes that operations are the whole of surgery and that any one who can secure primary union of wounds most of the time is a surgeon. His existence is due to the fact that our modern technique makes it possible to invade all parts of the body with impunity. He often announces himself as a specialist in surgery without having had sufficient training to justify any such step, and too often secures patients by dividing fees with that class of practitioners who have a higher regard for their own pocketbooks than they have for the welfare of their patrons. He frequently performs unnecessary and even unwarrantable operations, and often when an operation is indicated fails to relieve the patient of his suffering because the surgeon's ignorance and inexperience prevent him from recognizing pathologic conditions or from removing them when found. He classes every operation from which the patient recovers as successful, regardless of whether any good has been accomplished or not. Every surgeon is consulted by a host of people who have been advised by the radicals to submit to all manner of operations for which there is no indication and for which very frequently positive contra-indications exist. The radical, for want of surgical training and experience, as a rule, does not perform radical operations. He is very apt to remove the stones from the gall bladder and leave those in the common duct. He removes the prominent part of a malignant growth, leaving the outlying parts and the neighboring lymphatic glands. The sins committed by the radical are legion. . . ."

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[1] The *Journal of the A. M. A.,* March 20, 1909.

Perhaps the most absurd example of surgical sophistry was communicated to the *American Journal of Clinical Medicine*[1] by a distinguished Chicago physician. "On my recent trip to ———," he writes, "I learned from a young surgeon of that city that pus might form in the body without rigor, elevation of temperature, exudation, induration, swelling or discoloration; and that this was especially true in appendicitis—pain localized being the only symptom, and that this warranted an immediate operation."

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[1] The *American Journal of Clinical Medicine*, July, 1906.

The editor comments as follows:—

> "It seems presumptuous in an obscure individual like the writer to offer advice to the modern surgeon, but really we think the suggestion worthy of his serious consideration. In days of old, when the rage was for attributing everything to ulcer of the uterus, some worthy men in the front rank of the profession were nonplussed by failing to detect any ulcer in cases that really should have shown it to verify their theories. They, therefore, assumed that in such cases the terrible malady was there even when it wasn't—in other words that it was 'latent.' Now, why not have a latent appendicitis?"

I know a New York doctor, supposed to be a specialist—and still so considered by many—who was anxious to do a Kraske operation. He had never done one, but he had heard of the operation and was absolutely determined to avail himself of the first chance to perform it. In walked a poor old man, one day, eighty years of age, with senile debility and slight hemorrhoids, who complained of some pain along the lower part of the spine. The doctor, of course, saw a good chance to operate. Was this man of ninety suffering from cancer? The specialist thought he was, and thought so emphatically enough to advise operating immediately. The operation was an entire success. The poor old man died fifteen minutes after he had been put on the table, but the surgeon finished the operation and had the patient put to bed. He told the family not to disturb the old gentleman as the shock was sometimes severe, that if they came in the morning he was sure he would have a good report for them. The family came early enough, for they were sent for in a hurry at a quarter to two. When they arrived at the hospital the sad news was broken that the patient had just passed away. They were not allowed to go into the room, however, for fear of detecting the temperature of the body. The undertaker took charge of the remains. The family to-day are entirely satisfied with this surgeon's work. The tissues removed showed no evidence of cancer and the operation was unnecessary, but the family do not know that. The result of course was unintentional, but to advise operation under such circumstances was practically murder.

This same " specialist," being slightly discouraged by his Kraske operation, thought he would turn his attention to prostatectomy, which at times is decidedly difficult. The next person who placed himself at his mercy was a man forty-eight years of age, and perfectly healthy. However, the surgeon discovered that he had an enlarged prostate gland, and nothing must do but to gouge it out. The family consented and so did the patient. He also was the unfortunate victim of surgical zeal. The prostate was taken out, but the results were not satisfactory and death occurred four days later.

I could give many cases similar to these, in some of which the technique was perfect, but the operation unnecessary or the patient unfitted to undergo it. " The temptation to do a complete and perfect operation is very great," says the editor of the *American Journal of Surgery*.[1] " A successful operation is often done, but the patient dies." Addressing the City and County Medical Society of Portland, Ore. (Dec. 6, 1905), Dr.

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[1] *American Journal of Surgery,* September, 1909.

R. C. Coffey told of an acquaintance of his who operated on twenty cases of appendicitis with eighteen deaths, and cited an instance from Dennis of nineteen cases with nineteen deaths.[1]

" These men," says Doctor Coffey, " instruct the people that appendicitis means certain death unless immediate operation is resorted to. They thus distort the other and radical side of the subject, and bring discredit on the profession, for it is well known that not more than fifteen per cent. die, if left without treatment of any kind." Treated medicinally, Doctor Coffey might have added, the mortality would be less than one per cent.—that is, if the report of the French Army hospitals can be believed.

Of course, the cases just cited are exceptional, as even the average surgeon of the old school would have no such mortality; but the public hears so much from the surgeons (indirectly, of course) of their successful cases, that it is well to attempt to strike a balance. Dr. Samuel M. Brickner (of New York) evidently thought the same when he prepared his address to the Harlem Medical Society last year. " It is a common thing,"[2] the address begins, " in these days of highly perfected surgical technique to report a large number of satisfactorily operated cases, and to present the specimens derived therefrom. I make no comment upon this procedure. It serves a laudable ambition and a laudable purpose. But it has seemed to me that it might not be amiss, for once, to present for consideration some of the accidents," etc.

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[1] " The Present Status of the Treatment of Appendicitis: the Family Physician's Responsibility." Published in the *New York Medical Journal*, August 18, 1906.

[2] Published in the *American Journal of Surgery*, August, 1909.

Doctor Brickner deserves great praise for his temerity, and with such excellent precedent I shall proceed to give a few more cases of unsuccessful operations, which, by some strange oversight, have not been recorded among the brilliant achievements of modern surgery. First, however, let us consider what are the factors, apart from diagnostic judgment and operative skill, that make for success in surgery.

The greatest discovery in surgery since the employment of anæsthetics is undoubtedly asepsis, or Listerism up-to-date, which might be described as absolute cleanness. The surgeon's hands, and that part of the patient's body which is to be operated on, must be made scrupulously clean by the use of soap and water and scrubbing brushes, followed by one or more antiseptic solutions. The instruments and dressings have to be sterilized by boiling, or by steam or chemical solutions. Every modern surgeon knows that the observance of these precautions usually results in a clean wound, which heals quickly without pain or suppuration. Negligence of surgical cleanliness, on the other hand, invariably results in a dirty wound, painful, suppurating, foul, and dangerous both to the life of the patient and to the success of the operation.

The training in a modern operating room of a large hospital is such that surgeons and nurses perform their work in a cleanly manner almost by instinct. It is, therefore, a recognized principle that cleanliness is essential in operating and in the dressing of wounds, and surgeons who operate with dirty hands, or unsterilized instruments, are violating the most important law of modern surgery.

Dirty or careless surgeons fall into two classes:

Those who wilfully neglect their duty, and those who graduated before antisepsis was taught and consequently do not know any better. Now it is well known in law that ignorance cannot be pleaded as an excuse for crime or misdemeanor, so that in both cases, the modern surgeons who know, and the older ones who do not, surgical uncleanliness is malpractice in every sense of the word—in the former, wilful or criminal malpractice.

Should the merely ignorant surgeon, therefore, be excused because of his ignorance? I think not. This type is ordinarily a man of venerable appearance emphasized by a long gray beard, a relic of an earlier and (surgically) barbarous age. He might read up the progress of surgical science if he cared to, but he does not. Protected by inefficient laws, he roams about in senile complacency, dispensing incalculable suffering, deformity and death.

When an unprogressive operator of this description calls in a younger, modern surgeon to assist, the latter, as also the nurse, is fully aware of the blunders which are about to be committed. But professional etiquette forbids them to inform the victim, or the family, of the butchery they are to witness, to the shame and disgrace of true surgery that has to suffer for, and shelter, these gross incompetents. I am now referring to recognized surgeons, not to old practitioners who turn to surgery as a last resort. The latter, despite a lifelong experience in medicine, must be regarded as surgical novices and will be considered elsewhere as such.

Surgeon M., U. S. A., retired, was for many years a prominent physician and surgeon in one of our seaport cities. Thirty years ago, in the days of dirty hands, wooden-handled instruments and "laudable pus," he had been regarded as a skilful operator. But, although, as we have seen, what was surgery then is butchery now, Doctor M. saw no reason for modernizing his antiquated methods. In fact he seemed to take peculiar delight in repeating the boast: "You fellows wash your hands before operating, but I wash mine afterwards." All this was *entre nous*, of course, but even had it been otherwise it would have had little effect on his large practice, both civil and military, since he had the (to the laity) obvious advantage of age, whiskers—probably dashed with tubercular sputum, for the doctor was a consumptive—and a full surgeon's shoulder straps.

To illustrate Doctor M.'s methods, I will narrate a laparotomy (opening of the abdomen) that he performed upon a fine, athletic young man suffering from a second attack of appendicitis. It was what is called a "clean" case, that is, one in which the vermiform appendix was in a state of catarrhal inflammation without pus formation or abscess.

When the assistants and nurses had prepared the patient for operating, and had got their hands and instruments, and everything else, in a state of the most scrupulous surgical asepsis, the old doctor walked into the operating room, his unwashed hands in his pockets and a disdainful smile on his face as his eye took in the usual careful preparations. He refused to have his hair and whiskers bound about with a strip of gauze, as all others in the room had done, but as a concession to the head nurse (for whom he entertained a fatherly regard), he dipped his hands perfunctorily into a basin of antiseptic solution, without, however, cleaning the long, dirty finger-nails. He then donned a smock, took up an old-fashioned wooden-handled knife, and was ready for business.

In order to make what follows quite clear to the reader, it should be stated that the muscles of the abdomen are in three layers, and that the fibres of each run at a different angle, which gives a lattice work or gridiron effect. This is Nature's arrangement to secure the greatest possible strength in the abdominal wall. The modern operation for appendicitis, devised by Doctor McBurney of New York, aims to preserve this structural strength by separating the muscular fibres instead of cutting directly through in the same plane, as was formerly done. The McBurney method did not appeal to Doctor M., however, who cut his way, with a sawing movement, right through everything down to the peritoneum, the membrane immediately covering the intestines. The younger surgeons present shuddered at this needless mutilation, but " medical ethics " and official respect closed their mouths. When the peritoneum was opened and the intestines exposed, the venerable surgeon laid down his knife, pulled his smock to one side, put his bloody hand into his hip pocket and drew forth a plug of tobacco. He bit off a piece, then offered the plug to the others, who declined the honor. As he replaced the tobacco in his pocket a nurse hastened forward with a basin of antiseptic solution. There was a moment of breathless expectancy. Would he wash his hands before plunging them into the patient's abdomen? The doctor readjusted his spectacles, waved the girl back to her station, inserted his contaminated fingers into the gaping wound, and began feeling about for the appendix. The enormity of such an action cannot be fully appreciated except by surgeons and trained nurses, but its mere crudity ought, I believe, to appeal more or less to every reader. Had the incision revealed an abscess, the doctor's omission to wash his hands would not have been so serious, though entirely inexcusable as a technical blunder, but to shove dirty fingers into a clean abdomen means deliberately to expose the patient to the danger of fatal peritonitis.

The old surgeon had had plenty of experience, and so he soon found the appendix and drew it to the surface. He cut through its mesenteric attachments without tying the bleeding vessels, and then severed the appendix itself, without making the slightest attempt to prevent the intestinal contents from escaping into the peritoneal cavity. When he had tied the stump of the appendix, he pushed it back into the abdomen along with its still bleeding and unsecured vessels. The doctor now scratched his head with his bloody hand. Then he closed the abdominal wound with silver wire—wire!—through and through all the layers. By the way, modern surgeons invariably sew up each muscular layer *separately*, so as to make a stronger wall and to prevent a rupture forming afterwards. A dressing of *vaseline* completed this barbarous and antiquated butchery, called by courtesy a surgical operation.

As might have been expected, the results were bad. The patient's great vitality (or an interposition of Providence) prevented general peritonitis, but he nearly died from concealed hemorrhage owing to the untied blood vessels, which twelve hours later necessitated reopening the wound, after which the wire sutures cut badly and had to be removed. The patient made a long, lingering recovery after several weeks of misery, whereas a modern, clean operation would have put him on his feet in seven days. Several months later a hernia (rupture) formed in the scar, which was subsequently operated on and cured by another surgeon.

This eminent surgeon died recently and was buried with military honors. After the funeral, his first assistant, a passed assistant surgeon of high standing, was heard to remark: "We're all sorry the old doctor's dead, of course, but we'll have to admit that his death is a godsend to his patients."

Now, while I do not wish the reader to understand that Doctor M. was typical of the surgeon of advanced years, neither do I regard his methods as at all exceptional. Indeed it is safe to say that there are thousands of surgeons still practising such antiquated methods, and bringing shame and discredit upon the profession.

I cannot dismiss this phase of the subject without again referring to that abomination of the operating room—a beard. The object of surgical cleanliness is to get rid of all dust and foreign matter, for these substances harbor the microscopic germs of disease. For this reason, the entire operating force generally wear cloths about the heads to prevent the introduction of dandruff and dust from the head into the wound. But where is there a greater catch-all for dust, particles of food, dried soup, sputum, dandruff and all manner of disease-bearing débris than the beard? Dr. Nicholas Senn said: "No surgeon should wear a beard; a modest mustache is all he can permit himself." And not only is a beard objectionable as a dust sprinkler, but supposing the men wearing them are near-sighted and have to bring the face close to the wound—*the* *beard then actually gets into the wound.* I have seen this disgusting and lamentable accident several times, and invariably followed by pus infection.

Doctor Q., of New York, enjoys an excellent reputation as a surgeon, and his practice therefore is large and lucrative. It would seem that formerly he was a better operator than now; to-day he is certainly a menace to the community, and I have heard that several prominent surgeons are considering the propriety of exposing him as both irresponsible and dangerous. His deterioration has been ascribed to a drug habit, and this, if true, would readily explain it.

Doctor Q. recently operated, in a private hospital, on a simple case of varicose veins of the legs. The operation was tedious on account of the large number of veins to be attended to. After about two hours of work, and the end still far away, he became hungry and ordered a lunch prepared and served. When it was ready he suspended the operation and took a leisurely meal. During this pause for refreshments the patient was kept continuously under the influence of ether. When the surgeon's hunger was appeased, he washed his hands (I believe) and went ahead with the operation. This, of course, was an instance of flagrant malpractice—to interrupt a surgical operation under anæsthesia for any but the most urgent cause—and I have specially selected the case for the consideration of those antivivisectionists who are concerned about the scientific anæsthetizing of cats and dogs. To prolong anæsthesia unnecessarily is in direct violation of one of the main principles of modern surgery, yet it is only too frequently allowed by careless or selfish surgeons. Doctor Q.'s operation lengthened out to four hours, and might easily have proved fatal. Fortunately, however, the victim was able to endure the strain, and, I am told, recovered in time.

In view of the foregoing it will hardly surprise the reader to learn that Doctor Q. is careless and dirty in his surgical technique. The result is that most of his cases become infected with pus, which has earned for him the unenviable sobriquet of "Doctor Pus" at a certain hospital where he operates. One of the nurses employed at that institution said to me lately:—

"Nearly all of his clean cases are pus cases in the end, and the strange thing is that he never removes the dressings to see if the wounds are suppurating until you can smell the patients in the hallways."

Doctor K. is a well-known physician and surgeon in a Western seaport, and has a large practice. He graduated less than twenty years ago, and should therefore be reasonably modern in his surgical technique. But he does not keep up with the progress of science, and employs obsolete methods in hernia and other surgical cases. During operations on clean cases he frequently forgets to re-cleanse his hands after having handled unsterilized objects in the room, and he greatly resents having his attention called to such omissions, even though there is time to correct them.

One of his fatal cases, now to be recorded for the first time, was Mrs. G., a well-to-do woman of about sixty years of age, who had been complaining for some time of pains in the stomach and chronic indigestion. There was occasional vomiting, loss of general health and weight, and some tenderness on pressure over the upper abdomen, especially toward the right side. She had never vomited blood, which is nearly always present in serious conditions like ulcer or cancer of the stomach, but, considering her age and symptoms, and the fact that Dr. K. believed he was able to feel an abnormal mass under the left lobe of the liver and near the outlet of the stomach, the case did suggest cancer, though it was by no means typical. Dr. K. advised opening the abdomen and examining the stomach. Another and better surgeon who had also seen the case did not approve of an operation at that time, believing that the symptoms were not sufficiently definite, nor the patient's condition vigorous enough to expose her to the shock of laparotomy. Doctor K.'s counsels prevailed, however, and the lady went to the operating table.

Now Doctor K. is a very slow operator, and, as stated above, not sufficiently careful as to surgical cleanliness. In this instance, however, he planned to dazzle his assistant and the surgeon just referred to by an elaborate and original manœuvre in the department of asepsis. Before making his incision through the skin he buried the umbilicus (navel) by sewing the surrounding skin over it. A more futile and absurd proceeding can hardly be imagined, especially as the doctor did not wear the modern operating gloves, and his finger nails were not particularly clean. This preliminary detail consumed more time than should ordinarily have been used in opening the abdomen and exposing the stomach. In cases like this, every additional minute under the anæsthetic increases the danger to the patient.

When the stomach was at last exposed, no abnormal swelling or tumor could be found. The organ itself was somewhat dilated, but that was about all. Doctor K. felt the pylorus (the outlet), which was normally surrounded by a thick and firm ring of muscular tissue, and insisted that this was an abnormal swelling and the first stage of cancer. He insisted further that the cancerous condition encroached on the lumen of the outlet, obstructing the discharge of food from the stomach, thus accounting for the pain and vomiting. Much more time was now lost in arguing whether or not cancer existed, though for some reason he did not demonstrate the presence or absence of obstruction as he might have done by means of a very simple test. All this time the patient was growing weaker and responding poorly to stimulants.

Having convinced himself of the correctness of his diagnosis, Doctor K. was much inclined to attempt a resection, or cutting out, of the supposed cancerous parts of the stomach. But this was a formidable operation and would take him considerable time, so he abandoned the idea. The stomach, therefore, was put back where it belonged, the abdomen was sewed up, a dressing applied, and the patient removed from the operating room and put to bed. The operation took nearly two hours and the consequent shock was so great that the patient never rallied as she should have done. On the contrary, she gradually grew weaker, and on the fourth day died.

Here we have an example of a blundering and worse than useless operation. The abdomen was opened, the stomach and other organs were handled and exposed to danger from pus infection, but absolutely nothing else was done to them, nor did they need it. The whole affair was a combination of hasty diagnosis and a desire to perform laparotomy on a patient able to pay a good fee.

I shall give another lamentable case of Doctor K.'s, illustrating his criminal carelessness. Like that of Mrs. G., it has so far been omitted from his published reports of surgical achievements.

Mrs. J., a dressmaker, went to him complaining of a pain in the abdomen, which Doctor K. diagnosed as appendicitis. He accordingly opened the abdomen, in his none too cleanly manner, and found the appendix to be inflamed as he had surmised. After inserting several gauze pads, which is usually done to prevent the intestinal contents from getting into the peritoneal cavity and causing blood-poisoning, he proceeded to remove the appendix, and then, just for luck, the right ovary also. When ready to close the wound he pulled out, as he supposed, all the gauze pads, and then sewed up the various membranes.

Mrs. J. made a fairly rapid recovery, everything considered. She went back to her work sooner than was advisable, but then Doctor K.'s fee was high, and she was in straitened circumstances. Very soon, however, she began to experience abdominal pains again, which gradually grew worse until the poor woman could scarcely drag herself to and from her work. When she could endure it no longer, she returned to Doctor K. He listened to her symptoms and told her she had stomach trouble, for which he prescribed appropriate remedies. She paid for the advice and the prescriptions, but the medicine did her no good. Soon she began to develop a low fever and had to visit the doctor almost daily. All her scant earnings now went into his pocket, and she had to borrow money for further treatment.

Meanwhile Doctor K. became somewhat puzzled over the case, which he realized was not stomach trouble. He began to regret that he had not removed the other ovary. At last, however, the patient could work no longer, and as she had clearly reached the end of her resources he lost interest in her and discontinued his treatment.

About a month later some charitable ladies who had formerly employed her sent Mrs. J. to a private hospital and engaged Doctor C., a first-class, up-to-date young surgeon, to take charge of the case. He made a careful examination and found an abnormal swelling or bulging in the vagina just back of the uterus. He at once suspected the presence of a deep, pelvic abscess and advised immediate operation. The consent given, Doctor C. had the patient prepared, anæsthetized, and brought to the operating table. His intention was first to make an exploratory incision into the swelling, and then, if this did not reach the abscess, to perform another operation.

The first proved to be all that was needed. As the knife pierced the swelling a quantity of foul pus escaped. Passing his rubber-gloved fingers into the abscess cavity to ascertain its depth and direction, Doctor C. encountered a large semi-solid mass lying posteriorily. He was puzzled for a moment only, for to his experienced touch, the feeling of the mass against his finger was not new, though happily rare. It meant only one thing. Keeping his finger on the mass, he took a long dressing forceps in his other hand, guiding them carefully with his other fingers, and then slowly drew out a large, blood-soaked, stinking wad of surgical gauze.

" Medical ethics," of course, caused Doctor C. to refrain from exposing Doctor K.'s egregious blunder, but he did inform him privately of the circumstance.

Doctor K., however, was far from grateful, although Doctor C. had discovered and rectified his blunder, and protected his reputation; in fact, he became his secret enemy.

I discovered a similar blunder a few years ago when a poor, emaciated girl came to my ward in a New York hospital. This young woman, also, had been operated on for appendicitis, but the wound had never healed, and so she had undergone a second operation for supposed abscess of pelvic origin. The second operation failed to relieve her, and on carefully examining her I decided to make a third. After making a small incision posterior to the uterus through the vaginal wall, I noticed that there was something quite out of the ordinary. I inserted a finger and to my surprise felt gauze, and presently pulled out of the abdomen through the vagina a large abdominal gauze pad. The girl made an uneventful recovery. The surgeon who performed the first operation had forgotten to remove one of his pads.

Still another similar case that came to my notice, but one that ended more disastrously, occurred in Washington, D. C. A young married woman suffering from irregular hemorrhages was told that a thorough scraping of the uterus would cure her, and so she submitted to this operation. The surgeon, finding that he had troublesome bleeding to deal with, decided to pack the large and boggy uterus with gauze. This he did, and he also packed the vagina. Twenty-four hours afterward he ordered the nurse to remove the gauze, and the latter, carelessly, or in ignorance, removed the vaginal packing only. When the uterus had remained packed for three months, the suffering patient consulted an " expert." After due examination this specialist found that the uterus was abnormally large and hard, and decided that it was affected with " fibroid " and should be removed. So he performed a hysterectomy, only to find that he had removed a normal uterus filled with gauze, which the first surgeon and his nurse, between then, had carelessly overlooked.

An even worse case than the foregoing was that of Miss Donovan of Philadelphia, who died last year after eleven years of suffering, the victim of another surgeon's criminal carelessness. I will quote the account given in the N. Y. *Sun* of January 23, 1910, which is substantially correct:—

> " Philadelphia, Jan. 22.—After living for eleven years with a pair of forceps in her abdomen, Miss Mary Donovan died last Wednesday, following an operation performed to remove the instrument.
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> " Miss Donovan scoured the world in search of health following the first operation. At intervals she was seized by severe pains and medical experts failed to give relief.
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> " At the request of a specialist who was summoned to the home of the young woman to attend her, an X-ray photograph was made. The forceps was discovered and an operation ordered.
>
> " Dr. John G. Clark of the University Hospital was summoned and the operation was attempted. The patient could not stand the shock, however, and died."

That surgeons, and good surgeons, too, often overlook a gauze pad, a sponge, or even one or more instruments when closing a wound, the reader is no doubt aware—how frequently this deplorable blunder has happened, however, will never be known either within or without the profession. Many surgeons, moreover, admitting the terrible mortality among such victims of carelessness, nevertheless regard the accident as one that is bound to occur. "So long as surgery continues an art," writes Schachuer, "just so long will foreign bodies continue to be unintentionally left in the abdominal cavity." Truly a pessimistic outlook.

Dr. H. S. Crossen (of St. Louis) gives, at the close of a paper on this subject,[1] a table containing no less than two hundred and forty cases of a foreign body lost in the abdominal cavity. Commenting on his statistics, he says:

"The table includes only cases in which the abdominal cavity was involved. A number of cases given in other collections of foreign bodies left after operation were excluded because the operation involved the breast, neck, hip, etc., instead of the abdominal cavity. Other cases were excluded because the sponge or forceps was found before the abdomen was closed. Other cases were excluded because they were probably or possibly repeats.

"No particular effort was made to secure a large number of cases to date, by a prolonged search of literature nor by writing to surgeons for a list of personal cases. *A few recorded cases, more or less, make little difference, for these recorded cases represent only a small proportion of the total number of such accidents.*[2]

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[1] "Abdominal Surgery Without Detached Pads or Sponges." Read at the 21st Annual Meeting of the American Association of Obstetricians and Gynecologists, at Baltimore, September, 1908, and published in the *American Journal of Obstetrics,* January and February, 1909.

[2] Referring to the frequency of this accident, Dr. Archibald Maclaren (of St. Paul, Minnesota) in a paper read before the American Surgical Association, June 4, 1909, and published in *Annals of Surgery,* July, 1909, says: "*I find that every interne, when cross-examined, knows of at least one such case,* although they confess with great reluctance and never tell who the operator was." The italics, both here and above, are mine.

My object, therefore, is not so much to present a long list as to present a quick survey of authenticated cases of such variety and number that the careful surgeon will be led to pause and think on this matter.

"A sponge is the article most frequently left in the peritoneal cavity, but in about one-fourth of the recorded cases the article left was a forceps or piece of an instrument or other small object used about the wound. This calls attention forcibly to the fact that small instruments should not be allowed about an open abdominal wound. Neugebauer long ago called attention to this danger of small instruments, and urged the use of long instruments exclusively in abdominal work."

As a matter of fact this terrible sacrifice of life and health is no longer excusable, for several leading surgeons have attacked the problem with the conviction that it can, and the determination that it must be solved. And so we have the check system, whereby only a certain number of pads are laid on the operating table, every one of which must be accounted for, as well as every instrument, before the wound is closed. Even better than this, so far as the pads are concerned, is the system elaborated by Doctor Crossen in the paper from which I have just quoted, which eliminates detached pads and sponges entirely, the gauze being used in long strips, one end of which is fastened to the sterile sheet. Either of these two methods, preferably the latter, with the use of long instruments, will practically guarantee the patient's safety from this horrible danger—that is, with competent and conscientious surgeons. But so long as the profession enjoys its present irresponsibility, the old, haphazard methods will probably remain in general favor, with torture or death in store for many a luckless patient.

# CHAPTER VII

## MORE SURGICAL OUTRAGES

"There is something absurd, and unworthy of the high standing of our profession, in performing any operation, however slight, which is useless; but it is a revolting thought to perform one that is worse than useless, viz.: injurious."—Dr. Abraham Jacobi.

"The task before me is a serious criticism of what is going on in every community. I do not single out any community or any man. There is in my mind no doubt whatever that surgery is being practised by those who are incompetent to practise it—by those whose education is imperfect, who lack natural aptitude, whose environment is such that they never can gain that personal experience which alone will really fit them for what surgery means to-day. They are unable to make correct deductions from histories; to predict probable events; to perform operations skilfully, or to manage after-treatment."—Dr. Maurice H. Richardson.

In one respect, at least, the town or country patient enjoys an advantage over his fellow-sufferers in the large cities, and it is this: that a country surgeon is forever meeting the victims of his carelessness or incompetence—provided they live—whereas a surgeon in a large city is practically never confronted with the evidence of his mistakes. This unquestionably tends to equalize things, for if the latter possesses greater skill and experience, the former has much stronger cause to fear the results of his blunders. As an outspoken surgeon writes: "To those of us who live in cities not so large but that almost daily we meet on the streets some of the living monuments of the pleasing and displeasing results of our efforts, our successes or failures, these questions (the after-results of mastoid operations) become of more than passing interest."[1] Particularly is this true of amputations, which are in many respects one of the greatest reproaches to modern surgery. The time was when to attempt to save a limb, severely shattered or lacerated, was to subject the patient to the risk of almost certain death, whereas to-day, to amputate instantly, except in a case of hopeless mutilation, is a sign of criminal indifference on the part of the operator. Yet in our cities, where the busy surgeon has more cases than he can handle, or in the hospitals, where the ambitious internes have a multitude of helpless folks at their mercy to operate on as they please, amputations are constantly being performed where care and judicious treatment would unquestionably lead to the recovery and lifelong use of the limb so recklessly sacrificed.

Dr. W. Wayne Babcock, Professor of Surgery in the Medical Department of Temple College, and Surgeon-in-Chief to the Samaritan Hospital, Philadelphia, in a paper read at the North-west Branch of the Philadelphia County Medical Society, March 7, 1907,[2] reported the following scandalous condition in his own hospital:

> "A few years since there was an understanding in the service of the Samaritan Hospital that all amputations below the wrist were to be placed in charge of the resident physician, and as a result there soon arose quite a competition between members of the resident staff as to who should have, during the service, the largest

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[1] "Some Displeasing Results of the Mastoid Operation," by Dr. J. A. Stucky, in the *New York Medical Journal,* February 10, 1906.

[2] Published in the *Therapeutic Gazette,* September, 1907.

number of such amputations. We were amazed to find that amputations of the fingers constituted one of the most common of operations in the dispensary service, and at times several fingers were amputated in a single week. A rule was therefore enforced that no general anæsthetic should be given, and that no amputation be done, except under the direction of the attending surgeon or his qualified assistant. Although the dispensary service was progressively increased as to the number of cases attended, amputation of the fingers or the hand has become very infrequent."

Writing upon "Unnecessary Amputations," Dr. W. Louis Hartman (of Syracuse, New York)[1] gives several instances of patients saved from needless mutilation by his determined opposition to immediate amputation. He says:—

"One can just as well amputate some hours or days after injury as at once, and this without menace to the patient, and on the other hand save many members which are unnecessarily sacrificed. I understand it is much less trouble to take care of an amputation than of a fracture, but this must not stand in the way of duty. I do not know of any problem in surgery where good judgment and conservatism should prevail more than on this question, when to amputate and when not. I do not think internes in hospitals should ever be allowed to amputate without the counsel of the surgeon, as they are very often too eager to operate and their experience has at this time been insufficiently ripened to have the good sound judgment of the experienced surgeon."

It would be a waste of the reader's time to give instances of needless sacrifice of an arm or a leg—at least a third of the cripples one meets are cases in point, and several authorities would probably place the percentage much higher. Many of these poor creatures, however, lost their limbs before the present perfection of asepsis and so no blame can be laid to surgery which did well, a generation ago, to save the patient's life. But the average amputation of to-day, such as the case given in the succeeding chapter, where a woman sacrificed her arm to gratify a youthful surgeon's ambition, is undoubtedly ill-advised, a gruesome testimony to our criminal incompetence.

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[1] *International Journal of Surgery,* February, 1909.

In this connection I wish to present some remarkable examples of the result of care and skill in preventing mutilation. These are selected from a number of cases reported by Dr. John Egerton Cannaday, Surgeon-in-charge Sheltering Arms Hospital, Hansford, West Virginia,[1] who is an eloquent advocate of conservative surgery.

"Case 1.—D. M., male, aged 22, was referred to me by Dr. C. N. Watts, Dothan, W. Va.

"History.—The man had been shot in the left leg at about the junction of the upper and middle thirds by a Winchester rifle; the ball struck the tibia squarely and produced a badly comminuted fracture. An occlusive dressing was applied and the man kept in his shanty in a railroad camp with the hope that healing would take place. After six weeks of this, suppuration not only of the wound but of the entire leg below the knee had become so general that amputation was considered to be the only means of saving the man's life. At the time the patient came to the hospital he had severe chills, fever and sweats, but I decided to make an attempt to save the leg.

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[1] "Conservative Surgery of Arms and Legs."—The *Journal of The American Medical Association,* May 11, 1907.

"Operation.—Under general anæsthesia the wound was opened, cleansed and several fragments of dead bone removed; four long pus cavities were opened freely, irrigated and drained. These cavities lay in general in the direction of the muscle planes and were connected by sinuses with the original wound. One of them extended some distance above the knee joint into the thigh. Neither the ankle nor knee joints were involved. Under frequent dressings and irrigations some improvement of the leg was manifested, but during the next three months the patient had to be twice anæsthetized and new sinuses opened.

"Result.—At the end of the tenth week after admission to the hospital, the sixteenth week after the receipt of the injury, there was bony union and the patient was put on crutches. In a month he was walking in a limping manner, but the original bullet wound had not yet closed. The leg was painful when much used. Two subsequent operations had to be done for the removal of carious bone. These cavities finally filled and at the end of the tenth month of hospital residence he left well, with a straight, sound leg, capable of earning his own living and not likely to become a public charge."

"Case 3.—F. B., male, aged 21, a sawmill employee.

"History.—Patient fell so that his left arm came in contact with a rapidly revolving circular saw. Two and one-half inches below the elbow the forearm was more than two-thirds sawn in two. The radius was cut entirely in two and the articulate end of the ulna was torn completely out of the elbow joint and projected backward past the angle of the elbow for at least two inches. He was brought to the hospital about three hours after being injured and was operated on soon afterward.

"Operation.—The wound was irrigated with saline solution, the fractured ends of the radius were wired, and the elbow luxation was reduced. The wound was closed with the exception of a small drainage opening, and the arm immobilized in a right-angled splint. Healing was primary, and passive motion was begun at the end of the second week. Results were perfect and the man now has a normal arm with no elbow ankylosis whatever."

"Case 4.—G. H. W., Olcott, W. Va., was referred to me by Dr. W. W. Tompkins, Charleston, W. Va.

"History.—This man had been severely struck on the left elbow in an accident. The arm was terribly swollen, crepitation in the region of the elbow joint could be made out and not much else.

"Operation.—I made an incision lateral to the joint and found that the component bony parts of the joint had been crushed. I resected the broken end of the ulna, also the articulate head of the humerus, which was fractured entirely across its diameter. Through and through drainage was maintained for a time. A useful arm capable of considerable range of motion was the result."

It is a pleasure to cite such examples of well-directed conservatism, but I do not wish to be understood to say that surgical outrages are all on the operative side. The instances of lifelong misery and death from timidity on the part of the physician or of ultra-conservatism on the part of the surgeon are legion, and this applies to appendicitis, and even to amputations, notwithstanding the great preponderance of needless operations. "In intestinal obstruction," remarks Dr. Henry B. Luhn (of Spokane, Washington), "operation is often withheld until the diagnosis is written all over the belly, which is a fatal delay."

Writing upon this phase of the subject Dr. Q. W. Hunter (of Louisville, Kentucky) [1] says:—

> "It can be amply demonstrated that in surgical practice ultra-conservatism is an exceedingly dangerous institution when indiscriminately applied, and under no circumstances does the truth of this statement become more apparent than in a certain percentage of instances in which amputation of extremities becomes imperative as a life-saving measure, or because of extensive crushing injuries. *Per contra*, however, the fact must not be permitted to pass unobserved that it is in this department of surgical practice some of the most brilliant results have been achieved by strict adherence to conservative principles."

In the preceding chapter I gave a number of shocking examples of bad surgery as performed by surgeons of the old school or by careless or inexpert operators. It would be unfair to these blunderers, however, and misleading to the public, were I to omit the mistakes and catastrophes of the higher men in the profession. Here it is hard to say just what measure of blame to apportion. All men in all professions make mistakes at times, even with the greatest care and devotion to duty. But some great surgeons, notwithstanding their brilliant achievements, are notoriously careless and indifferent to the lives of their patients. The following cases are instances of such carelessness; otherwise I would not have recorded them.

I was once invited to a surgical clinic held by one of the most noted surgeons in New York City. Expecting to see something out of the ordinary I attended, and certainly was not disappointed.

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[1] "The Futility of Ultra-Conservatism in Destructive Injuries of the Extremities."—The *Medical Council* (Philadelphia), January, 1907.

A woman was to be operated on for some kidney trouble, and the surgeon, after a lengthy discussion of the case before a number of physicians, stated that he would not operate if he were not sure that the diagnosis he had made was correct.

The operation was performed, but the kidney proved to be absolutely normal. This surprised the surgeon, and turning to the house surgeon he inquired for the history chart. After looking it over he exclaimed: "Who prepared this patient? I thought you told me it was the left kidney!" There was an awkward silence for a few seconds, whereupon the humiliated surgeon, recovering his self-possession, put back the left kidney and sewed the woman up. Then he had her right side sterilized, and operated upon the other kidney.

If this blunder was not the surgeon's fault, it was unquestionably his duty to see that the offender was found and punished. After the operation the patient's condition was serious. She lived, however, and an apparently satisfactory explanation followed as to why they had operated on both kidneys.

The following case occurred in the practice of a well-known New York surgeon:—

The patient was a young girl of about fifteen, the daughter of a wealthy family. One day she was taken ill with appendicitis and the surgeon in question was called in. He examined the patient carefully and advised operation. The consent of the family was obtained and the operation duly performed. The patient made an uneventful recovery.

While still in bed, however, she received an invitation to a ball which was to be given on the tenth day after her operation. She was particularly anxious to attend this ball, being very fond of dancing, so she sent for her surgeon and asked his permission to go. He consented, strange as it may seem, for he is a first-class operator and must have known that the edges of an abdominal wound do not unite with complete firmness for about eighteen days.

The young lady got out of her bed on the tenth day and went home. She was still weak, but, girllike, she insisted on dressing for the evening's entertainment. It is probable that she neglected to wear an abdominal binder, as it might have spoiled the fit of her gown.

The evening wore along merrily. The excitement made the girl forget her fatigue and she danced until early in the morning.

Suddenly she felt a sharp burning pain in the abdomen where the operation had been performed. She fell to the floor and was immediately carried to her room. When her clothing was removed her mother was horrified to find that the wound had burst open and that the intestines were protruding.

The surgeon was summoned immediately. He was greatly shocked at what had happened, and ordered the girl to be taken at once to the hospital. He hurriedly telephoned for his assistants, and then to the hospital, instructing them to be prepared for an immediate operation.

On her arrival at the hospital the girl was at once placed on the operating table, an anæsthetic was administered and a second operation performed. But in spite of the greatest care and precaution peritonitis developed within twenty-four hours and was shortly followed by collapse and death.

The fatal termination in this lamentable case was due to the amazing and criminal carelessness of the surgeon who permitted his patient to get up and dance on the tenth day after a laparotomy.

The following sad case which occurred recently in the practice of a well-known gynecologist of Greater New York resembles that of the poor Italian woman given in an earlier chapter. The details were related to me by a physician who was present at the operation. The patient was a woman of thirty, and as her case had been diagnosed as fibroid tumor of the uterus, the eminent surgeon had invited a number of doctors to witness him perform the hysterectomy (removal of the womb). This operation may be performed in two ways, either by opening the abdomen and taking out the organ from above, or by a more delicate operation which removes it through the vagina. In the present case the surgeon decided upon the latter method. My informant had no opportunity for careful examination prior to the operation, but he did not feel entirely satisfied with the diagnosis of fibroid tumor.

The patient was put under the influence of an anæsthetic and then placed on the operating table. When the field of operation was properly prepared, the gynecologist had retractors introduced into the vagina so as to expose the cervix or lower end of the womb. He seized this with a long sharp forceps, drew it downwards, and then examined the part with his fingers. Meanwhile he had been explaining the case to his audience at considerable length, for he was a good speaker and well versed in his subject.

As his practised fingers examined the cervix and the adjacent portion of the uterus he hesitated in his talk, and finally ceased to speak. An expression of doubt began to show in his face. Presently he remarked that the cervix felt much softer than usual in fibroid cases. After a further period of silence, during which he continued to palpate the uterine area within reach of hand and eye, he stated that as there were some peculiar features in the case he would be on the safe side and thoroughly explore the cavity of the uterus before clamping the ligaments and blood-vessels preparatory to cutting away the diseased organ.

Accordingly he drew the cervix down again as far as possible and passed his index finger into the uterus. He had ceased to speak now and the visiting medical men stood around the table silent and interested, wondering what the condition could be that had so suddenly nonplussed the great specialist.

The operator's finger had encountered something, a movable body that could be nothing else than a small internal fibroid tumor attached to the uterine wall by a pedicle, or band of fibrous tissue. The doctor's face cleared as he explained all this, and presently, with a dexterous twist of his fingers, he brought the supposed tumor down through the cervix and into full view.

Judge of his disgust and chagrin when the "fibroid tumor" turned out to be the leg of a three-months' child! He had now gone too far to draw back, for the case could never go on to full term. There was therefore no other course possible than to finish the miserable job. Furious with anger and humiliation, the doctor extracted the entire fœtus and applied a dressing. The unfortunate woman, her chances for motherhood destroyed, was removed from the table to her bed, and the clinic broke up without the expressions of felicitation customary on such occasions.

During the afternoon the woman began to bleed profusely. The house surgeon did his best to stop the hemorrhage and sent for the chief. The latter could not be found. The patient's condition became worse. The house surgeon exhausted all the means at his command, short of immediate removal of the uterus, but to no purpose. The hemorrhage came from the retained and torn placenta or afterbirth, which the chief surgeon did not dare to remove with the fœtus for fear of causing the very condition which developed later. All efforts to locate the chief surgeon, however, were unsuccessful until late that night, and in the meantime the hemorrhage had proved fatal.

Now it is an unwritten law among surgeons to remain within call for some time after a serious major operation. They need not actually remain in the building, but are expected to leave word as to their itinerary so that they can be reached by telephone or messenger, should alarming symptoms develop. In this case it was most regrettable that the surgeon failed to leave correct information as to his whereabouts during the rest of the day and night. His unquestionably superior skill might have averted the crisis that his own blunder had caused.

The unfortunate case, with its unexpectedly fatal ending, however, made a profound impression on him, as may be inferred from the fact that he spent the next few days drinking heavily. To a man of any conscience or sensibility such a catastrophe must inevitably bring with it humiliation and remorse, and it is safe to say of this surgeon that his future patients will benefit by the sad experience, in that they are far less liable to be the victims of insufficient examinations, hasty diagnosis and unnecessary operation.

Of the occasional blunders made by famous surgeons, none is more striking than one I myself witnessed some years ago, which I will now relate.

A Chicago surgeon, whom we will call Doctor A., a man of international fame, and one of the pioneers in intestinal surgery, performed one day, before his students, the operation of gastroenterostomy, or connecting the stomach with a section of the small intestine.

Before the operation, and while operating, Doctor A. gave the history of the case and the symptoms and signs upon which the diagnosis had been based. He then referred briefly to his own well-known experiments with animals, and those of other surgeons, which were made to determine the extent to which surgery might interfere in abdominal disease, such as the length of intestine that might be removed in cases of complete obstruction, the manner in which wounds of the bowels healed, and the best kind of stitches and quality of suture material. This was intended to lead up to a description of the ideal operation that had been conceived and made possible as the direct result of all these remarkable experiments. He told how, in obstruction of the outlet of the stomach from any cause, an artificial connection might be made between the wall of the stomach and a portion of the small intestine a little way beyond the obstruction. As he operated he described the various landmarks that must guide the surgeon so that he would be sure to seize the right loop of small intestine and not make the fatal mistake of sewing the large intestine to the stomach. He told how the large intestine could be identified by the presence of certain bands running along its length, and so forth.

The operation was performed in the great surgeon's rapid and masterly manner. The patient was removed from the operating room to bed, and soon rallied from the shock, so that all promised well.

When it came time to feed him, however, the nourishment did not seem to afford relief. There was imperative hunger both before and after eating. The patient grew weaker and more emaciated. Nothing could relieve his constant demand for food,—something to satisfy his raging, abnormal hunger. Death occurred within a week, and on the following morning, the body, being that of a charity patient, was taken over to the morgue at Cook County Hospital for a post-mortem examination.

The morgue was crowded with students and physicians, though for some reason the great surgeon himself was not present. The pathologist who performed the autopsy was a great man in his specialty, and later became an author of note. Rumor had it that he and the aforesaid surgeon were not on the best of terms, to put it mildly, and this presumption lent an unusually keen interest to the autopsy that was billed for that morning.

Before beginning his examination the great man caused the clinical history of the case to be read aloud to the audience. After dictating a few appropriate remarks and describing the external appearance of the body, he proceeded with the examination of each internal organ. His usual routine was to begin at the head and work downward. He did not alter it in the slightest particular now, though well aware that the interest of all present, and for that matter, his own, centred almost entirely in the abdomen. So he examined the organs of the neck and chest, one by one, with exasperating thoroughness, as it seemed to the impatient students.

At last, however, he reached the abdomen and retracting the skin and muscles on either side, he surveyed its contents *en masse*. After describing these he began to draw the omentum to one side. The students breathed a little more quickly now, and some stood up so as to get a better view. Several who had brought opera glasses were greatly envied.

As the pathologist pulled the omentum away and exposed to full view the area of the recent surgical operation he paused. An expression of surprise appeared in his usually impassive face. He bent down more closely over the body and manipulated the stomach and intestines. The students held their breath. Not a sound was audible.

When the pathologist looked up, his face had resumed its wonted expression, in which mere personalities had no place or interest. His brief announcement, so far as I can remember it, was as follows:—

"Gentlemen: You will remember that the history of this case states that the operation of gastroenterostomy was performed last Friday. You will be aware, from your studies under Professor A., that gastroenterostomy means an anastomosis between the stomach and the upper portion of the small intestines, preferably the first part of the duodenum. In this case, however, the operation has been performed somewhat differently. I find that the stomach is joined, not to the small intestine, but to the transverse colon of the large intestine."

It came like a bomb-shell, this announcement of the famous surgeon's fatal blunder. Of course everyone could now understand the patient's piteous craving for nourishment. The food had passed from the stomach directly into the large intestine, where it could not be assimilated without having been previously acted upon by the digestive juices of the liver, pancreas and small intestines. The unfortunate victim had actually starved to death.

One of the most ghastly mistakes in the annals of surgery is a case I will now narrate. It was described in the newspapers a few years ago, and many will recall the horror that the case aroused. Unfortunately it is not the only instance of the kind on record.

A noted Western eye specialist was treating a patient for a serious inflammation of the eyeball. The case was rather obscure, and it was not till after repeated and careful examination that a diagnosis of glaucoma was made. This is a very serious disease, and it often becomes necessary to remove the diseased eye in order to prevent a sympathetic inflammation of the normal eye, which would render the unfortunate patient stone blind.

The patient's condition became worse and the sympathetic inflammation which the specialist dreaded seemed imminent. He put the case plainly to his patient. The latter, dreading the thought of total blindness, finally consented to the removal of the diseased eye. The operation was performed and performed well. Both eyes were bandaged and the patient was put to bed in a darkened room.

On the following day the doctor called to dress the wound. When he removed the bandages the patient complained of the darkness and requested the doctor to open the blinds. A cold chill crept over the doctor. The windows were wide open—it could mean only one thing. He could not speak for the horror of the thought. The patient raised his hand to his forehead, and then the awful truth broke upon him. The specialist had taken out the normal eye and left the blind one.

I do not know what passed between the surgeon and his blinded victim after the revelation came. A lifetime might be lived in that hour of anguish and despair. No reparation could possibly be promised or made.

And yet the surgeon took what seemed to him the only course indicated by honor after the desolation he had caused and could not undo. Several weeks later he entered the foyer of a large hotel and shot himself.

Such cases of over-confidence or criminal carelessness, and thousands of examples might be added, surely dispose of the idea that the only fault in our system lies in the preparation and training of the surgeon, and that when a high educational standard is set and maintained and all incompetents are weeded out, surgical outrages will be a thing of the past. This is based on the assumption that all surgeons are possessed of superhuman attributes and hence should be amenable to no law. Surgeons are but men, influenced by various motives, subjected to strong temptations. Granted a license such as no other body of men possess, and restrained only by general social and economic laws, and such interpretation as they choose to give to their self-imposed code of "ethics," is it to be wondered at that they assume an arrogant superiority towards the general public, and hence often come to value lightly the health and even the lives of the helpless folk who are so completely in their power? It is true that this very irresponsibility brings out, in some, the noblest traits and highest altruism; but only too frequently it breeds a cruelty and criminal recklessness that is simply appalling to those who know.

These latter cases also show how great must be the danger of mistake on the part of the operators of limited experience or mediocre ability, when the most skilful surgeons are so liable to err. Surely the moral is that a most careful diagnosis should precede any surgical interference, that no factor that contributes in the slightest to the good of the patient should be neglected,[1] and, that contrary to the dictum of a noted gynecologist, the rule should be: *when in doubt don't operate.*

" I am not the bold operator whom you knew years ago in Zurich," wrote the great surgeon, Billroth, to a friend. " Before deciding on the necessity of an operation, I always propose to myself this question: Would you permit such an operation as you intend performing on your patient to be done on yourself? Years and experience bring in their train a certain degree of hesitancy."

" Every period of medical science has its fascinating catchwords," writes Dr. Otto Glogau (of New York) in *American Medicine.*[2] " Those of the present are appendicitis of the adult and adenoids of the youth. How many healthy appendices and how many strips of pharyngeal mucous lining, supposedly adenoids, may have been victims of bold science!" Continuing, he says:

" The present view as to the treatment of adenoids is their local removal; the same attitude was formerly maintained by the profession towards treating affections of the thyroid gland, which, when hypertrophied and causing mechanical and general symptoms in a similar way to the adenoids, was completely extirpated at a time when our knowledge of its function was very scanty. But to-day, with our advanced knowledge of *cachexia strumipriva*, even the most daring surgeon is conservative in preserving a portion of the gland. Perhaps later on when the adenoid fury (furor adenoidicus) will calm down and we learn to recognize the symptom complex of *cachexia adenoipriva*, the physician will be more conservative in operating on an organ, the function of which is still unknown."

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[1] See Appendix C, containing an interesting and instructive account of the work of the famous Mayo Brothers in Rochester, Minnesota.

[2] " Nasal Obstruction in Children."—*American Medicine,* April, 1909.

Writing upon " Tubercular Peritonitis in Women,"[1] Dr. James N. West (of New York) says:—

" Osler states that fully one-third of the cases of tubercular peritonitis operated upon received this treatment under the mistaken diagnosis of ovarian cyst. I will add that I believe that fully another third of them are operated upon under the mistaken diagnosis of ordinary pyosalpinx. Perhaps, then, two-thirds of the cases in women receive a correct diagnosis only after opening the abdomen for some other disease. A considerable proportion probably die as a result of a complete failure to make a correct diagnosis."

The following plain language is from a remarkable article on the surgeon's sins both of omission and commission, entitled " Frenzied Surgery of the Abdomen." It was contributed to the *New York Medical Journal*[2] by Dr. J. W. Kennedy, who is associated with Dr. Joseph Price of Philadelphia:—

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[1] A paper read before the New York Obstetrical Society, March 9, 1909, and published in the *American Journal of Obstetrics*, May, 1909.

[2] The *New York Medical Journal,* November 23, 1907. This article is quoted in full in Appendix D.

> "Incompetent surgery has made the practitioner a doubting Thomas and results in a tardy diagnosis with high mortality.
>
> "Over eighty per cent. of our appendical work for the past two months has been pus, gangrene and peritonitis, which is a flagrant disgrace to the diagnostic ability of a large educational centre, and we can hope for little in the future unless our leaders stand for first hour operations.
>
> "We had in the hospital at one time ten patients, on whom twenty-seven sections had been done, all pitiable examples of errors in diagnosis, incomplete surgical procedures, and frenzied surgical judgment from an anatomical, physiological and pathological standpoint.
>
> "During the last six months nearly fifty per cent. of our work consisted of re-operations. Multiple scars marred the abdomen and were reproachful neglects of the untrained surgical mind. The sins of the operator had been visited upon the patient to the third, fourth and fifth scar. The patient has been made a chronic invalid and often an unwilling victim of some drug habit.
>
> "Surgical achievements of the competent operator are so minimized by the incompetency of others. The complications incident to previous operations are a greater source of mortality than the lesion itself. Late and faulty diagnosis, incomplete procedures, and errors in judgment of pathological nature have brought us mortality which is an insult to the advanced surgery of the day."

And so I could go on adding testimony to testimony, and many from our highest authorities in surgery.

Some of these are ready to preach but forgetful in practice, while others are doing everything in their power to exalt the profession and stamp out the abuses I have endeavored to expose. Let me conclude with one more quotation, from a paper by Dr. J. L. Wiggins,[1] from which I have borrowed the title of this chapter:—

> "Things which were permissible or even commendable under past conditions, are at present high crimes or misdemeanors. With the opportunities now available in morgues and clinics to see and study living dead pathology, there exists no excuse for repetition of our former mistakes. We know that it takes more than the ability to cut and sew to make a surgeon. We know that a recent graduate, except in rare instances, is not competent even to operate. We recognize the wide distinction between the words 'operator' and 'surgeon.' We know that skill, confidence and judgment in any vocation come from constant repetition. We know that we, as individuals, would not select the occasional operator for ourselves or our families in any matter of serious import. We are capable of protecting ourselves; are not the public entitled to like protection?"

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[1] "Surgical Outrages," by Dr. J. L. Wiggins (of East St. Louis, Illinois). The President's address delivered to the Ohio Valley Medical Association at French Lick, Indiana, November, 1908, and published in the *Lancet-Clinic,* November 14, 1908.

# CHAPTER VIII

## THE SURGICAL NOVICE

"Between the young graduate in medicine and his ultimate responsibility—human life—nothing interposes. He cannot nowadays begin with easy tasks under the surveillance of a superior; the issues of life and death are all in the day's work for him from the very start."—Abraham Flexner in *Carnegie Foundation Bulletin* No. 4.

If it seems to the reader that the illustrations of surgical incompetence given in the preceding chapters are exceptional, and that the average surgeon, by reason of accumulated experiences, must have acquired a high diagnostic and operative skill, what is to be said for the young doctor who begins the practice of surgery without any experience whatever?

Everyone knows what happens when a man takes up an art or trade—he begins by spoiling a lot of material, that is, unless he is watched and constantly aided. Thus the printer's devil gets the type mixed in the fonts, and the shoemaker's apprentice wastes leather, and the amateur cook spoils the broth, and all are restrained in proportion to the value of the materials with which they work. An apprentice at sea, having been an able seaman or a midshipman for a number of years, enters upon the higher duties of navigation as a junior officer, where he remains many years more under the careful supervision of his seniors. Otherwise he might sink the ship, and ships are too valuable to be placed in charge of a tyro.

But the graduate of a medical school, who knows less about the actual technique of surgery than the printer's devil knows about operating a linotype machine, may settle down in this land of liberty, and practise any sort of surgery without let or hindrance. Of course, if he is wise and really ambitious, he will endeavor to enter a hospital, or try to secure a position as assistant to some capable surgeon; but this is as he will. He may elect, and in most cases he does elect, to practise independently, making his unfortunate patients pay for his mistakes. And the material he wastes? Only human limbs and organs, and, of course, human life itself.

Of the 4,741 students who graduated in this country in 1908, probably a thousand, or more, have by this time attempted at least one major operation which they were no more competent to undertake than a newly-fledged boatswain is competent to navigate a battleship through a hurricane. And many of them, bear in mind, are not graduates of the few moderately efficient institutions that we can boast of, but come from the hundred and one ill-equipped little colleges that I have already attempted to describe. Truly the American public is long-suffering in more ways than one!

Of course, by " novice " I do not mean only the recent graduate. Perhaps even a worse offender is the older practitioner who, without any practical experience in surgery, and with but hazy memories of the hospital operations that he witnessed in his youth, " brushes up " by reading the few obsolete works on surgery that he may happen to possess, and presto! he is a full-fledged surgeon.

I knew an old physician, Doctor O., who, after twenty-five years of general practice, suddenly decided to go in for surgery, because, as he explained, " there's more money in that line of work."

Almost his first case was a young man who, as a result of fast living, had developed an infection of the glands of the groin, which were hard and nodular and quite prominent. Doctor O. quite properly advised that the glands be cut out, and the young man, having entire faith in him, left the matter in his hands. As the operation was a simple one, Doctor O. decided to operate himself, and this was the result.

Cutting the glands out he cut altogether too deeply into the groin and accidentally pierced the femoral artery (the main artery of the leg). After an exciting time the hemorrhage was stopped and a ligature put around the artery. The operation of course came to a standstill, and the patient, who was nearly dead from loss of blood, was put back to bed. But the blood supply being cut off, gangrene soon set in, and the leg had to be amputated at the hip joint. A real surgeon was now called in to perform the amputation, but the shock was too great and the young man died.

Fortunately for the public, Doctor O. gave up surgery and is now practising medicine again, but in another city.

A similar case was that of a physician of Des Moines, Iowa, who thought he would like to specialize in rectal work. Accordingly he came to New York to learn all he could by taking a three months' course, and returned home ready to perform any operation pertaining to this specialty.

One of his first victims was Mrs. K. C., who had large external and some internal hemorrhoids (piles). Of course, operation was advised, and as Doctor N. was supposed to have made this work a life study, the patient's consent was readily secured.

The operation was performed, and the hemorrhoids were clamped and seared off according to the approved methods of the day, or at least the doctor thought so. Nevertheless, the patient developed a stricture of the anus, which at times occurs when a novice operates, and the new " specialist " did not feel very well about it. Instead of treating the stricture as he should have done, however, he advised an immediate second operation for the formation of an artificial anus. This was done, and the poor patient condemned to a life of wretchedness simply because she had been so unfortunate as to place herself in the hands of a tyro. As a matter of fact, the deluded woman thinks she owes her life to this " specialist," but some day she will probably learn the bitter truth.

Another novice, although a surgeon of some standing and connected with a New York hospital, recently mistook a chronic inflammation of the tongue for cancer. He advised an immediate operation and took out the tongue, including the glands of the neck and almost everything he could get at without destroying life upon the operating table.

After the operation a specimen of the tongue and glands was sent to a pathologist for his report on the case. Three days later it came—" Simple inflammation of the tongue; glands not affected," —whereupon the surgeon and the pathologist had a bitter altercation. But events proved that the latter was right, and that a healthy tongue had been ruthlessly destroyed.

Had this butcher in the first place removed a small snip of the tongue for microscopical examination, the true condition would have been revealed to him. But in that event he would have had no excuse for operating.

The fact was that he had never before taken out a tongue and wished to do so very much. When the opportunity came, he elected to maim the patient for life rather than risk losing the case.

It may seem incredible, but it is no less a fact that many novices in surgery have such an imperfect knowledge of anatomy that they are unable to recognize certain internal organs when they see them, and not infrequently they mistake one for another. The next case is an example of such "surgery."

Mrs. G., a lady of wealth and of high social position, had suffered from several attacks of appendicitis. On the last occasion but one she called in the gentleman whom I will call Doctor R. The reader has already guessed correctly that Doctor R. advised an immediate operation. Mrs. G. consented, and after undergoing an operation of some sort, made an uneventful recovery. The bill was a large one, but was duly paid, and both patient and surgeon went on their way rejoicing.

Mrs. G. never ceased to congratulate herself that she was now and for all time free from the dangers of appendicitis, and hence retained a lively gratitude toward the skilful surgeon to whom she owed her immunity. She was ever ready to sing the praises of modern surgery, and her favorite theme was the diagnostic acumen and surgical skill of Doctor R. As might be expected, this lady's gratitude and enthusiasm were the means of bringing many patients to the fortunate doctor, and his fame and income grew apace.

A little more than a year had passed when, rather suddenly one morning, Mrs. G. developed pain in the neighborhood of the appendixless region. Other alarming symptoms followed, and in a few hours she was forced to admit that she had an attack that much resembled her former attacks of appendicitis. Of course she lost no time in sending for Doctor R., but much to her regret he was for some reason unable to come to her, so, on the recommendation of a friend, she sent for Doctor S., a really capable surgeon.

After the latter had examined her and learned the history of her case, he said:

"Really, Madam, I don't know what Doctor R. may have done to you, but you have appendicitis now."

Mrs. G. was thunderstruck. "How can that be, Doctor," she exclaimed, "when Doctor R. removed my appendix more than a year ago?"

"I can't say as to that," he replied; "all I know is that you have appendicitis now."

What did it mean? How could she have appendicitis without an appendix? Could it be possible that she had two appendices and that Doctor R. had only removed one?

In the absence of Doctor R. she continued to employ Doctor S., and as her attack was severe, it soon became apparent to the latter that an operation must be performed. Doctor R. returning about this time was astonished at the condition of his former patient. Arrangements had already been made to have Dr. S. perform the operation, but on Doctor R.'s request he was courteously permitted to be present.

Doctor S. was a much more experienced, skilful and rapid operator than Doctor R. As soon as the patient was fully under the influence of the anæsthetic, he reopened the abdomen. In a few minutes he drew forth before the astonished eyes of Dr. R. a typical vermiform appendix, though badly inflamed. Dr. R. was rendered speechless by this convincing demonstration, but when the operation was nearly completed he was heard to exclaim:

"My God! If that is her appendix, *what did I take out?*"

This case is by no means exceptional. There are many so-called surgeons who could not tell an appendix from an ovary.

Doctor Senn records a case somewhat similar to the one just described, but here the sequel proved that fraud had been practised. The patient, a woman, had been previously operated on for appendicitis by two obscure doctors. They told her that the appendix had been cut out, and showed her a specimen in a bottle. Afterwards she developed an acute attack, and Doctor Senn himself removed her appendix. She instituted legal proceedings against the two impostors, and, I believe, was awarded damages.

In this connection I might mention a group of reputable charlatans who pretend to make diagnoses of serious abdominal or other internal conditions, and then persuade the victims to undergo operation. The patient is brought to the operating table and put under the influence of an anæsthetic. The false surgeon makes an incision through the thickness of the skin, but no more. This he sews up again and applies a dressing. The patient believes that she (for it is generally a woman) has been operated on and the cause of her trouble removed. If she is of a hysterical, neurotic type her absolute faith in the impostor may result in some real benefit. The operator gets his fee and everybody is pleased. This is a highly profitable and tolerably safe form of surgical charlatanry, and it is probably employed to a far greater extent than most medical men are aware of.

The two following cases, like that of Dr. O., illustrate the wanton sacrifice of life by the inexperienced or over-ambitious novice. Innumerable fatalities similar to these have occurred and will occur so long as such "legalized assassins" are permitted to operate at will.

A young surgeon of New York, who is famous in his own household, was anxious to perform a gastroenterostomy. This is the formidable operation, described in the preceding chapter, for the relief of cancer or ulcer of the stomach. It consists of connecting the stomach with a loop of intestine beyond the obstruction. Doctor M. had been looking around for years for a victim, and at last an 86-lb. man was carried into his office. When he caught sight of this man's emaciated condition he immediately suspected cancer somewhere, and "gastroenterostomy" flashed through his brain. There was, of course, only one thing on earth to do, and that was to cut into this poor cadaveric individual and satisfy his surgical aspirations.

He accordingly opened the abdomen, sewed the intestines to the stomach and treated the man as well as he knew how, which is not saying much. Four days were enough to finish the poor creature. After he had passed away, the surgeon turned the case over to his assistant and begged him, in a quivering voice, to please protect him and explain to the family. He also asked him if possible to secure the consent of the family to a post-mortem examination, as he was anxious to find out if any of his stitches had held. The assistant made the request, but the family, being devout Catholics, refused point-blank. This surgeon stood in with the undertaker, however, and just before the unfortunate victim was carried out of the hospital he went with both hands into the abdominal wound and found, much to his disgust, that the stitches had not held, and that the broth he had given to the man twelve hours before his death was in the abdominal cavity.

Doctor M., though he would resent being called a tyro, is certainly not an expert in this particular branch of surgery, and from the way he operated there will be many more victims before he becomes proficient. A few years of study under Dr. William Mayo might have lessened his self-confidence.

A poor woman took her boy, suffering from tuberculosis (consumption) of the spine, to a New York clinic, hoping that some relief might be obtained. It was a strange case and had puzzled many medical men, though all agreed that the disease was absolutely incurable. There was one dissentient voice, however, that of a young surgeon whose confidence and ambition usually got the better of his judgment.

This genius, whose boasted skill has since lost for him what little reputation he ever had, saw his chance to operate on the poor dying creature. After explaining to the mother what might happen if certain things were not done immediately, he frightened her into sending her unfortunate boy into the hospital to have his life fairly cut away.

Before entering the hospital, however, the mother was consulted as to how much money she had. She told the young surgeon that her husband had just been buried, and that every cent she had in the world was eighteen dollars. The young man replied that she could pay fifteen dollars down for the operation and the balance when she was able.

So the poor mother sacrificed her scanty means as well as her son's life, for he lived but a short time, and the heartless surgeon did not even see him after the operation.

As a matter of fact this surgeon must have known that the prognosis was sure death, and that there was no possible hope of surgical interference helping the boy. But he also knew that the mother was strong and able to work for a living, and that she had eighteen dollars, fifteen of which would line his pocket temporarily. He therefore took advantage of this poor creature, not altogether for the money, but for a chance to operate at her expense.

The following, I will frankly admit, is an exceptional case, though our " system " would permit of its recurrence just as often as greed and ignorance might dictate.

A young man was graduated with honors from a certain Eastern university. But although he had no hospital training and poor medical judgment, his successful work on paper made him a licensed doctor, at liberty to plunge into any branch of medicine or surgery. He chose surgery, and with more sense than the average graduate, attempted to gain admission to a New York hospital.

Unfortunately the opportunity did not occur. Hospitals are controlled entirely by cliques. Unless one has the key to the forbidden door one is never able to enter the inner circle. The key represents money, influence, social standing, pressure, grit, perseverance, pull and moderate ability. For certain reasons this young man could not enter the *real* clique.

But his family had money. After trying in vain, therefore, for a number of years to get the son into one of the city hospitals, the alternative presented itself of directing their efforts to the establishment of a new hospital, over which he should preside as chief and only surgeon. And this was actually done.

In due course of time the hospital was opened. People were given to understand that it was a charity hospital and run conjointly by the City and the State Board of Charities. It was, however, a one-man affair, made and controlled solely by this one shrewd young doctor whose ambition in life was to become a surgeon, regardless of human suffering, or of bereaved friends—in short, regardless of everything but his selfish ambition. So he is to-day the proud possessor of a small hospital, surrounded with a clique of puppets whose positions on the staff are kept by them because of their ability to furnish patients who pay the great benefactor for the privilege of being operated on, how and when and where he may elect. Yet this institution has on its Board of Directors a number of prominent men who are hoodwinked into thinking they are conducting a charity hospital.

Surgical catastrophes at this establishment cannot possibly be prevented, for there is no one to dictate to the surgeon. It is, as I have said, a one-man hospital over which he is lord and master. It was founded for him, it is run for him, it is controlled by him, and he alone reaps whatever benefit there is in it.

He entered the ranks a few years ago as an apprentice. With little natural ability he is blundering along, practising surgery on a large percentage of the patients, and yet showing but little more skill than when he performed his first vivisection. That which he should have learned in an accredited hospital under a good surgical tutor he is slowly acquiring at the expense of these poor patients who look upon him with reverential awe, not knowing on what a diminutive pedestal he stands. And yet he is not wholly to blame, since his application for admission to the established institutions was so persistently refused.

Our laws, of course, afford no protection to the poor innocent sufferers who place themselves in his care, and the public have no conception of the conditions that prevail. Many an unsuspecting victim enters its portals without the slightest chance of ever returning to his loved ones.

Associated with this ambitious gentleman was another novice who had all the energy necessary to make a successful surgeon, but none other of the absolute essentials, namely, the skill and science which come only from long study and training under a master.

This colleague was called suddenly to the hospital one morning to see a woman who was brought in with the upper bone of the arm fractured. In receiving this fracture she had suffered severe contusion, so that the arm was black and blue from one end to the other.

The young surgeon examined the case very carefully, according to his way of thinking, and with hardly a word of warning to the patient, decided that instead of setting the arm he had better amputate.

The next day, much to the horror of the patient and her friends, the young surgeon took off the arm, explaining that unless it had been done gangrene would have set in, and the woman have died from blood poisoning.

This, I will admit, is one of the most outrageous cases of malpractice I have ever known. It was a simple fracture that this novice had to treat, but instead of putting up the arm in splints and giving nature a chance, he performed a mutilating and wholly unnecessary operation, making the woman a cripple for life. Such a monstrous blunder may seem almost incredible, but the facts are exactly as I have related them.

A malpractice suit, I believe, is, or was, on foot. If it comes up for trial the young man will have several of his clique upon the stand to swear that there was nothing else to do under the circumstances. They will perjure themselves, of course, but this, as I have shown, is the proper etiquette under such compromising conditions. Many another surgical malefactor has escaped in this manner, when, if justice were done, he would now be serving time in the State's Prison, or waiting his turn in the electric chair.

The same assistant had an ordinary case of metrorrhagia (bleeding from the uterus) to treat, but instead of using simple methods, which in six ordinary cases out of ten will effect a cure, he decided to take out the uterus through the vagina. This is a difficult operation, requiring great surgical skill and anatomical knowledge. A vaginal hysterectomy, done by such men as Dr. J. Riddle Goffe, or Dr. Howard Kelly of Johns Hopkins, although a serious operation, would undoubtedly be successful. But for a novice to attempt the removal of the uterus, even though his diagnosis were correct, is something inconceivable. Ordinarily it would mean that such a man was entirely lacking in common sense. In the present case, however, I have reason to believe that it was the deliberate act of a human fiend whose sole desire was to get all the difficult operations possible, regardless of results, in order to perfect himself as a surgeon.

The operation was ordered, the patient consented, and everything being in readiness, he proceeded to slash away. After cutting through the upper tissue as rapidly and dashingly as possible, he cut clean into the bladder. Of course, as the urine trickled down over his hand he realized his mistake. But instead of stopping the operation at once, as he should have done, allowing a fistula to form and thus giving the woman a chance for her life, he next proceeded to cut in through the abdomen and sew up the bladder, afterwards removing the uterus by the abdominal route. It is scarcely necessary to say what happened to the poor patient. She, at least, can never testify to the criminal incompetence of those to whom she entrusted her life.

I have since seen this young man do some very good surgery, and some very poor surgery. The good surgery that he has done has been simple surgery; the poor surgery has been difficult surgery, which means that he is not capable, and possibly never will be, of becoming a great surgeon. He should be suppressed, and if he attempts to operate on any more difficult cases, his license should be revoked. He has no more earned the right to perform a major operation than a first-year student.

This scandalous state of affairs, unlike some of the abuses I have endeavored to expose, has long been realized by our leading physicians and surgeons, many of whom have scathingly denounced the evil in the medical press. But the attacks have been, at best, desultory, and the "ethics" of the profession has always stood in the way of an organized campaign against the offenders. To seek general publicity, and sound a note of warning to the victimized public, would be unpardonable disloyalty, and few have dared attempt such radical measures. Yet there have been several notable exceptions, and even in England, where conditions are immeasurably better than in this country, a reputable physician has braved the wrath of his conservative associates by contributing an article to a lay review, advocating the legislative control of surgery. I refer to Dr. James A. Rigby, whose paper, "The Surgeon's Power of Life and Death," will be considered in a later chapter. In the lay press of this country, I know of no such drastic proposal since January and February 1897, when the *Arena* published a symposium entitled "A Court of Medicine and Surgery." This, however, was ineffective since the public knew little of the evils which the proposed "court" should abolish.

Turning to the medical journals, we find sufficient authoritative testimony to convince the most exacting tribunal that the indiscriminate practice of surgery by young graduates, in fact by all novices, is but another name for butchery—human butchery. And the excerpts here given are but a haphazard selection from scores of similar protests.

Dr. J. H. Percy (of Galesburg, Illinois), President of the Illinois State Medical Society—"Some of the Problems of the Internist Which Concern the Surgeon." A paper read before the Illinois State Medical Society (Section on Medicine), May, 1906, and published in the *Illinois Medical Journal*,[1] August, 1906:—

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[1] For a fuller report of Doctor Percy's paper, and the comments thereon, see Appendix E.

"There are too many men going into surgery as soon as they leave the medical school. I met one of them a few years ago. He had had his diploma just two weeks. He was an average graduate of a medical school with a good reputation. This young man had not prepared himself specially for anything but good average work. He had not had the training of the average hospital interne, he had not served as assistant to a real surgeon, he had not got up his surgical technique by animal experimentation, he knew nothing of the practical application of asepsis or even antisepsis, neither had he learned in the great school of general practice; yet this doctor, who was just two weeks out of the opera chairs of his medical school, announced to me that he was ready to cut anything. And he did. Circumstances favored him so that he got surgical cases, and for a year or two he was literally doing surgery. Is he doing surgery to-day? No! Surgery has done him! He is in a position now where he has to commence all over again, if he wants to be a surgeon. But he probably never will. If the actual results of this man's work, while he was attempting to practise surgery, could be known, it would be a record heart-rending in the extreme. Some of you say that he was a fool. No, he was not. If I thought he were, I would not have made him a part of this paper. Neither would I have mentioned this case if it were an isolated or uncommon one. But what I have just described is being enacted in scores of places not only in this state, but in every one of our states. If human life and suffering count for anything, as they do, then this is a condition of affairs that, to put it mildly, is unfortunate for the most desirable and truest advance of both internal medicine and surgery."

Editorial in *American Medicine*, September, 1908:—

"The surgical fledgling whose education has been acquired in a post-graduate course of instruction, and whose sole conception of treatment is summed up in a cutting operation, is all too common. Unlimited assurance—such as ignorance often confers—and business ability may give him an undeserved prominence in a community; but viewed in his true light he is a disgrace to the specialty he professes to follow, and to him is attributable no small share of the distrust on the part of the physician towards surgical modes of treatment in internal diseases.

"But the profession has the right to demand—and so has the public—that no one shall be entitled to practise general surgery until he has fulfilled certain fundamental requirements, and these, at the minimum, should consist of an interneship in the surgical service of a hospital and an adequate term of clinical work under supervision of a competent surgeon, at least as regards major operative technique."

Dr. J. L. Wiggins (of East St. Louis, Illinois). From the paper quoted in the preceding chapter:—

". . . . By the time he graduates he is imbued with the idea that surgery is the only department of medicine worth considering. This position is accentuated if perchance he has served a short period in some hospital as an interne. To this end every endeavor is directed to the exclusion of much that is essential for general practice. When the latter subject is broached he becomes listless, deems interest an element of weakness; but mention a gastroenterostomy, and note the heightened color, the flashing eye, the nervous interest. Thus the heroic appeals alike in medicine and war, and each has its background of blood and carnage.

"Suppose we go a step farther—the post-graduate school. Here the matter of surgeon making is taken up supposedly where the medical college left off. In truth, it is at a period remote, when much that is indispensable for intelligent operative work is forgotten. Notwithstanding this, a finished product warranted not to shrink or fade is guaranteed in a six weeks' course of instruction irrespective of fundamental attainments, practical experience, anatomical or pathological knowledge; and this finished product is manufactured largely by watching some expert operator working at a distance."

Dr. Henry B. Luhn (of Spokane, Washington)—"Conservatism in Surgery." A paper read before the Associations of the Pacific North-west (Section on Surgery), July, 1909, and published in *North-west Medicine*,[1] January, 1910:—

"Twenty years ago but a small percentage of the graduates took up surgery as a special feature and kept apace with the surgical world. Now, in consequence of the wonderful advance in operating which is made perfectly safe or nearly so on account of the perfected technique, the majority of young men are taking up surgery, and flaunting themselves upon the public as surgeons without special preparation, and with very limited personal or practical experience. I do not question for a moment the right of these 'embryos' to take up surgical work, but I do question the justice to themselves and their patients when they fail to take a special training and thoroughly equip themselves.

"By these young men of no experience much harm is being done to surgery, as they realize that they can operate with very little danger to the patient's life, and they operate with little idea of what they really intend doing; and, further, their experience is so limited that they are not really capable of recognizing a pathologic condition when they see it. This class of men will, without an intelligent idea of indication and a diagnosis made only for the patient, attempt operations that have come into prominence through able operators and men of wide experience. The patient will survive, the operation may be noted as a success, though probably no benefit has resulted and oftentimes the patient is made worse.

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[1] Portions of the discussion following Doctor Luhn's paper are given in Appendix F.

"This observation holds true especially in gastrointestinal anastomosis, or gastroenterostomies. A few years ago this was a most popular operation and it seemed that almost every man who ever opened a belly was doing it, and I do not hesitate to state with but a limited percentage of benefits, and a large percentage of patients being made worse."

Dr. Henry H. Cordier (of Kansas City, Missouri)— "Some Elements of Success in Surgery." A paper read before the Thirty-fifth Annual Meeting of the Mississippi Valley Medical Association, October, 1909, and published in the *Lancet-Clinic*,[1] January 15, 1910:—

"Our medical schools, the teachers, the short postgraduate courses, and the surgical demonstrations to transients, of individual operators, are in a measure responsible for the many disasters in surgery that are of daily occurrence. This is no idle fancy of mine, but can be seen any day if you will visit the open-door hospitals or the many private sanitariums that are springing up all over the country. I do not desire to do an injustice to the well-qualified surgeon, with his private hospital, he who has, by hard conscientious labors, fitted himself for this great work. All credit is due to him, and of such there are many. It is the young graduate who, with no practical experience as an assistant, with no hospital training; or the older practitioner who takes a post-graduate course of six weeks in all branches, and suddenly blossoms out as an universal specialist; or he who witnesses a few operations by a skilled surgeon, goes home, takes a night's sleep, and awakens the next morning a full-fledged surgeon, in his own mind. I am dealing in truths, not exaggerations, when I make these statements.

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[1] Doctor Cordier's paper brought out an interesting discussion, portions of which will be found in Appendix G.

"Now, what are the results of this state of affairs? Operations are begun that, if completed, are attended with a high rate of mortality; if they are not completed, the case is pronounced an inoperable one, and the patient goes from bad to worse, and either dies or seeks a surgeon who completes the operation with much difficulty and an increased mortality, caused by the previous failure and delay. Organs are sacrificed and functions are destroyed by untimely delay and bad surgery. The patron of the surgeon has much coming to him, and our every effort should be to give him all that skilled modern surgery implies."

"But why multiply these groans?" asks a medical writer, facetiously, commenting on such conditions as are herein described. "The young cub must learn for himself by bitter experience, and e'en though 'the paths of glory lead but to the grave,' still we may pluck some flowers and avoid some thorns after awhile."

This voices only too well the genial optimism of the average doctor. "It is hard on the public, but they will stand for it, and we have to learn—and there you are!" But will the public stand for it when they hear the facts—the whole gruesome recital of unnecessary sufferings and mutilations and deaths?

"Our tolerant attitude," writes Dr. James E. Moore,[1] from whom I have already quoted, "is no longer tenable, because these evils are growing, and unless we are outspoken in denouncing them, the whole profession will be condemned for the sins of the few. When the laity wakes up, as they will in the near future, they are likely to have drastic laws enacted which will overshoot the mark and be a serious handicap to legitimate surgery. It behooves the profession, therefore, to give these grave matters careful consideration, and to map out a definite course for their suppression."

To sum up the situation, the surgical novice before very long will come to be regarded as an anachronism—a relic of barbarism. He may yet claim thousands, even hundreds of thousands of victims, but his bloody record is being investigated and will soon be published broadcast, and it is but a question of time until his unsavory career has been brought to a close. Whether by the remedies suggested in the final chapter, or by some unlooked-for short-cut to reform which even the long-suffering American public have at times been known to effect—whatever the procedure, the ultimate suppression of this horrible and altogether useless form of human butchery seems inevitable.

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[1] "Conservatism in Surgery." From the *Journal of The American Medical Association,* March 20, 1909. Doctor Moore, who is Professor of Surgery in the University of Minnesota, contributed an outspoken letter to the symposium in the *Arena* above referred to, and deserves great credit as one of the pioneer reformers in this field.

# CHAPTER IX

## THE AMATEUR ANÆSTHETIST

" The general administration of anæsthetics as performed to-day is the shame of modern surgery, is a disgrace to a learned profession, and if the full, unvarnished truth concerning it were known to the laity at large, it would be but a short while before it were interfered with by legislative means—and properly so."
—Dr. J. M. Baldy.

We now come to another novice to whom the hapless patient is frequently exposed, a bungler who is often employed by the most skilful and conscientious surgeons, yet whose ignorance and incompetency are responsible for innumerable fatalities. I refer to the untrained anæsthetist.

" Anyone and everyone thinks he can give an anæsthetic ," writes Dr. James Taylor Gwathmey [1] (of New York), " and yet there is nothing that requires such constant practice in order to attain perfection. No sleight-of-hand performer should ever rehearse his part oftener than should an anæsthetist who wishes to be master of his art. No one should give anæsthetics who does not have this daily rehearsing in some public hospital."

" Furthermore," he writes in another paper, read before the American Medical Association,[2] " because a man has given an anæsthetic many times during his hospital service and irregularly afterwards, it is no evidence of his ability to do the same thing several years after, with even a reasonable degree of success."

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[1] " Warm versus Cold Anæsthetics." From the *New York State Journal of Medicine,* February, 1908.

[2] Fifty-seventh Annual Session, June, 1906 (read in the Section of Laryngology and Otology).

Continuing, he says:—

> "The wonderful advancement in all departments of medicine has come from men devoting their exclusive time to some one branch of it, and especially is this true of anæsthetics. We are indebted to England, where the professional anæsthetist prevails in hospitals as well as in private practice, for all recent progress in the administration of anæsthetics. Here in America, where both nitrous oxide gas and ether were first discovered and used, we seem still content to continue what might be called 'frontier' or 'border' life, with the mortality table the same as when anæsthetics were first introduced."

Commenting on Dr. Gwathmey's paper, Dr. R. C. Myles[1] (of New York) regretted that statistics of the fatalities due to anæsthesia could not be obtained. Those who have lost patients do not give the statistics for publication. They are perfectly willing to confer with one another on the subject, but not with the profession at large in the way of publication. He had frequently asked surgeons in different parts of the United States as to deaths from anæsthesia, and it is rarely the case that they had not had a fatal accident, but he did not believe that five per cent. are reported.

Doctor Gwathmey's paper, and the discussion that followed, created quite a sensation at the time, with the result that several symposia have been held on the subject by medical bodies, and in the medical press.

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[1] As reported in the *Journal of the American Medical Association,* October 27, 1906.

"This subject," said the *Medical Times*,[1] editorially, "is of primary importance, though we would hardly think so from the haphazard and incompetent manner in which narcotism is induced. The patient is then really on the borderland between life and death, and much too frequently has this line been crossed in the most ghastly manner when the exhibition of adequate skill and the observance of essential precautions would have obviated any such fatality. Much too frequently, we repeat, and much oftener than the statistics would lead us to suppose."

The attitude of our nation toward surgery and anæsthesia is certainly unique. America is the home of some of the greatest surgeons that the world has ever known, yet we allow a host of incompetent graduates to mutilate or kill as they please; and though the birthplace of modern anæsthesia, the discovery of which has brought relief to countless thousands, we permit the administration of anæsthetics by any Tom, Dick or Harry who can be pressed into service. The surgical novice at least has a smattering of theories and vague memories to guide him, if nothing better—the amateur anæsthetist may be anybody at all, down to the office boy. He may know less about the action and dangers of chloroform than a Bowery burglar.

A few years ago a young graduate came to my office and asked if I could employ him as an "expert anæsthetist." I talked for some time with him, but he failed to convince me, although he insisted that he had used chloroform and ether many times and was thoroughly capable. I felt sorry for him, but was forced to decline his "expert" services.

In spite of this, however, we became quite friendly, and some months later he called me in consultation to see one of his patients. The case was obscure and an anæsthetic was necessary before the examination could proceed. He therefore volunteered to "give a little chloroform," and I foolishly allowed him to go ahead.

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[1] The *Medical Times*, February, 1907.

When the anæsthetic had almost done its work I asked him if the patient had false teeth, fearing that he might have overlooked this important detail. His answer was, "I don't know, but I think not," and before I could turn my head he had disappeared to ask some member of the family. He came back with the news that the patient had a small plate, which he hurriedly attempted to take out.

Quicker than it takes to tell it, this "anæsthetist" had pushed teeth and plate down the patient's throat and was making desperate efforts to regain them. After an exciting time, during which the half-conscious patient nearly choked to death, I was lucky enough to get the teeth. This little experience was enough for me and he never gave anæsthesia again, even to his own patients, with my consent. Afterwards he admitted that he "guessed he was a little careless."

Shortly after this episode, while this young incompetent was administering chloroform for another physician, the patient quietly passed away on the operating table. The last I heard of him was that he has given up chloroform as it "is not a safe anæsthetic to give," but "ether is perfectly safe." So I suppose he is still acquiring experience at the expense of the unsuspecting public.

There are many reasons why anæsthetics should be administered only by experts, not least of which is the greater freedom with which the surgeon can work when he is not troubled about his patient's condition. With a good surgeon and a capable anæsthetist the average patient has every possible chance of recovery, but with a good surgeon and a poor anæsthetist the results are often little better than if both were novices, since the surgeon's attention is divided. Even assistants and nurses, when they see the blunders of an untrained anæsthetist, are apt to become worried and forgetful, and so what should have been a smooth and successful operation becomes a series of mishaps, all due to the one disturbing factor.

Here are a few of the accidents to which the tyro who attempts to narcotize a patient is liable, and which I myself have witnessed.

The patient vomits repeatedly, or his tongue falls back into the throat, causing him to choke. At such times the anæsthetic must be temporarily withdrawn, and, in the latter case, the jaws have frequently to be forcibly opened. If there is danger of suffocation, a mouth-gag has then to be inserted—an operation that invariably loosens the teeth—and the tongue grasped by some barbaric instrument that cuts or bruises it almost beyond recognition. The mucus is next swabbed out of the throat so strenuously that for days after the patient can hardly swallow.

After these drastic measures, during which the operation has been entirely suspended, the patient has probably awakened, and is very likely kicking so violently that half the operating staff are needed to keep him quiet till more ether or chloroform is administered.

Sometimes a patient "comes out" of the anæsthetic at the most critical moment. The abdomen, perhaps, is opened and the intestines being examined; surgical instruments, gauze pads, towels, and other necessary appliances are on a small table directly over the patient's body, when suddenly, without a word of warning, the whole paraphernalia is upset and the technique of the operating room spoiled. Sterilization must now be begun all over; but if the patient is in danger, the work must be hasty, and it is a lucky thing if infection does not set in.

In one case, similar to the above, that I witnessed, the young anæsthetist had been paying too much attention to what the surgeon was doing, and, mortified by his remissness, he administered such an overdose of chloroform that the patient was several hours in recovering consciousness. Whether this particular patient recovered or not I cannot say, but the chances of death or permanent disablement are certainly the direct result of these wholly avoidable blunders.

Before continuing my indictment of the amateur, however, I wish to mention a grave abuse practised by some of our leading surgeons, viz., delay in operating upon a patient already anæsthetized. The case of Doctor Q., narrated in a previous chapter, who interrupted an operation on an anæsthetized patient to have his lunch, is an example, although I never heard of another outrage quite so flagrant, but the instance I will now give is, unfortunately, only too common.

The attending surgeon of one of the large New York hospitals, a man deservedly famous, had a large office practice, as might well be imagined. This private practice often encroached on his hospital duties, especially in the morning. On such occasions it was customary for the house surgeon or an interne to telephone the great surgeon to inquire when he might be expected at the hospital and when to prepare the first patient for operation. Doctor R. would then glance at the list of patients waiting in his ante-room, and after making a mental note of the approximate time each would require, he would issue instructions to begin the anæsthetic at a certain hour. Whereupon he would resume his consultations and only too frequently forget all about the operation and the poor charity patient about to be anæsthetized or perhaps already well under the influence of chloroform or ether. Another telephone message would often be necessary to remind him of his engagement, and of the flickering life he had so thoughtlessly endangered.

On one occasion he had proved unusually forgetful, but on receiving a hurried call for instructions replied that he would start immediately for the hospital. He accordingly rushed through his office cases, got into his automobile and started downtown. On the way he met a brother practitioner whom he courteously took aboard, and then sped on. On passing a café, however, both men discovered that they needed a stimulant, and, of course, appropriate action followed. While they were enjoying their Scotch highballs at the bar, a third brother strolled in. Naturally they must all three have one together, and as a matter of etiquette the newcomer must reciprocate, and so on. In the genial atmosphere of the saloon time was forgotten until some chance word reminded Doctor R. of his patient, who had now been under the anæsthetic more than an hour. A final hasty drink, and the trio were speeding along again, the red cross displayed for the benefit of zealous policemen. After two more stops, to let off the other gentlemen, the surgeon arrived at the hospital, rushed up to the lavatory and was soon in the operating room. The patient was not in very good condition after the prolonged anæsthesia, but Doctor R. was a skilful and rapid surgeon and the operation was soon finished. The patient was removed from the table to his bed still alive, and therefore the operation was accounted a success.

The criminal indifference shown by surgeons in thus keeping a patient unnecessarily under an anæsthetic could not be too severely condemned, for it means the deliberate jeopardizing of life, not to mention the grave after-results should the patient survive. The fact that prolonged anæsthesia is always highly dangerous should be an incentive to all ambitious and conscientious surgeons to operate just as rapidly as the nature of the case will permit. None know this better than the surgeon just referred to, yet to take in a few extra dollars and to be a good fellow with his brother practitioners he was willing to expose a poor charity patient to the risk of instant death. This may sound harsh and exaggerated, but it is the simple truth about a state of affairs that no civilized community should tolerate for an instant.

I could cite many cases that have come under my own notice of death or permanent injury following the reckless administration of anæsthetics, but I prefer to present the views of others who are specially informed on this subject. As a matter of fact, a few isolated examples might create a wrong impression, for I sincerely believe that were a public investigation called for at the present time, *the employment of trained anæsthetists, or the adoption of adequate measures for the safety of the patient, would be found to be the exception rather than the rule.* But let us take a few brief extracts from the testimony of those who have thoroughly investigated the matter.

From "Chloroform Anæsthesia," by Vere V. Hunt, LL.D., M. D. (of Blackwell, Oklahoma). The *Medical Brief*, May, 1906:—

"'The giving of the anæsthetic is really the most serious part of every surgical operation.' How complacently have we heard our preceptor state this fact when we were students, and how complacently have we many times since repeated the assertion. Yet how recklessly do we use, or permit the use of, this dangerous adjunct of surgery!

"The time above all others, for watchfulness, is the moment or two at the end of the stage of excitement, when, with rigid muscles and blue skin, the exhausted patient passes into complete narcosis. These critical moments are nearly always characterized by deep breathing, and the fatal dose of anæsthetic is most often inhaled at this time. Chloroform should at this time either be entirely withdrawn, or given most cautiously, in very small amounts, diluted with an immense amount of air. Yet it is generally at this most critical moment that the anæsthetizer, rejoicing in what he deems the conclusion of a perhaps tedious task, takes his eyes off the patient and tells the waiting surgeon—who should himself be paying sufficient attention not to require to be told—'Go ahead! I've got him under.' Too often has such action got the patient under—the sod."

From "A Primer on the Administration of Ether," by Henry S. Weider, M. D. (of Philadelphia, Pa.). The *Therapeutic Gazette*, December, 1907:—

"There are few in the medical profession, excepting surgeons and those experienced in anæsthetizing with ether, who realize its seriousness and the importance of its proper, careful, and scientific administration. Even among surgeons who would not think of allowing a trained assistant to tie a ligature or sew up a wound for them, there are those who will often, and without the slightest compunction, entrust the administration of the anæsthetic to a student, nurse, or inexperienced anæsthetist. Only too common among general practitioners is the custom, in the course of a difficult confinement, of leaving the administration of the anæsthetic to the nurse (often not even trained), and of guiding directions as to when to add more ether by the amount of outcry or resistance the patient makes."

Indeed I can instance a confinement where the physician employed the services of the much agitated young husband. In this case chloroform was used and in such excess that the patient almost expired. After the delivery a hemorrhage set in which was only stopped when the weakened mother was again at death's door. The patient was in an enfeebled condition for weeks, owing to this asinine doctor's stupidity.

From "Anæsthesia and Anæsthetics at Our Lady of Lourdes Hospital, Hot Springs, South Dakota," by W. J. McRoberts, M. D. The *Chicago Medical Times*, December, 1909:—

" The surgeon who performs the operation is always named, but who ever hears of the anæsthetist? When you stop to consider the matter, and in the interest of the patient, is it not the anæsthetist who takes the life of the patient in his hands to care for and guide through the most dangerous of ordeals to which the patient, for the purpose of prolonging his usefulness to his family and to the community, submits himself? . . . Because of his accuracy in surgical diagnosis, his skilful touch, and scientific technique, the patient's life is in very much less danger from the operation, as performed by the modern surgeon, than it is from the anæsthetic as administered by an untrained anæsthetist using slovenly and obsolete methods."

From "The Anæsthesia Peril in American Hospitals," by John B. Roberts, M. D. Read before the Philadelphia County Medical Society, October 23, 1907, and published in the *Therapeutic Gazette*, February, 1908:—

"During a recent visit in a metropolitan medical centre I was shocked at the reckless manner in which general anæsthetics were given. Observations during my surgical life in some ten or more hospitals in which I have operated has convinced me that a protest against the methods often pursued in American hospitals is urgently needed.

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"It is rather difficult for me to comprehend the attitude of many operators toward general anæsthesia. They seem willing to entrust the life of the patient to any assistant who is willing to assume the responsibility of giving the ether. They then proceed to the operative work with apparently no further thought of the danger of asphyxia, cardiac arrest, respiratory failure, or subsequent lung or liver symptoms from ether poisoning, than if they were working in a surgical laboratory on a cadaver. I cannot avoid the conclusion that no inconsiderable number of deaths attributed to post-operative shock are instances of anæsthetic death, due to a preoccupied operator and an ignorant or careless anæsthetist. I have sat on clinic benches and stood near operating tables more than once with thankfulness in my heart that the safety of no friend of mine was then in the hands of operators and anæsthetists so indifferent, or so oblivious, to the risk of ether and chloroform."

From "The General Practitioner as an Anæsthetist," by Douglas C. Moriarta, M. D. (of Saratoga Springs). The *Journal of The American Medical Association*, September 4, 1909:—

". . . . Why should not a patient have as much right to expect and exact skill in this branch of medicine as in the treatment of a fracture, in pneumonia or typhoid fever? And if a civil action were brought to recover alleged damages, and your attorney attempted to prove you qualified as a competent anæsthetist at the trial, how much teaching or clinical instruction could you certify as having had? About all that the average practitioner could say, if called on to prove himself qualified, would be that he was a regularly graduated physician and surgeon, and supposed to know and be familiar with anæsthesia. And, I ask, what percentage of us have received clinical training or instruction in the administration of anæsthetics? The number is so small that it is a disgrace to our colleges. And the general teaching has not materially improved. Even at this present writing there are only a few of our colleges where this most important branch of our curriculum is taught clinically; and, to repeat, is it not a disgrace to those in which it is not? And, if the actual state of affairs were appreciated by the public, even by the board of regents, would not a reform be demanded in this particular?"

From "Tonsils and Adenoids," by J. Martine Kershaw, M. D. (of St. Louis). The *Clinical Reporter*, January, 1910. Doctor Kershaw copies a list prepared by Dr. Francis A. Packard (of Philadelphia)[1] of the deaths of 29 infants and children "attributable to the use of a general anæsthetic in the removal of tonsils and adenoids," and comments thereon as follows:—

"The table shows that, apart from the operations, children die from the anæsthetics employed while operating. But the number that die from the anæsthetics employed and from the operations themselves will never be known. Surgeons publish their successful cases, but few care to report their failures. It is most painful to a surgeon to lose a case and he dismisses it from his mind as soon as possible. We are all human, and it is but human under such circumstances to forget."

From "The Trained Anæsthetist," by M. Porter, M. D. (of Dayton, Ohio). The *Lancet-Clinic*, June 18, 1910:—

"Some of us have seen patients die from anæsthesia, and it is not a very pleasant experience. Many have had the patient stop breathing for a few moments, and that is an experience we do not care to have happen very often. Yet the majority of doctors treat anæsthetics lightly, and some delegate the giving of chloroform in obstetrics to the husband or the nurse while they use forceps in the delivery. Is there anything in the practice of medicine where we are as careless as in this one of anæsthesia? Would the surgeon allow some one to handle his instruments with unclean hands, or some of the laity to assist him in an operation?

"Placing a patient's life in unsafe hands has always seemed to me one of the most hazardous things in medicine and surgery, but it is practically what is done when the anæsthetic is given by some one who has had little experience. I will venture to say that if any doctor had to have an operation performed upon himself or a member of his immediate family, he would hesitate and consider the subject thoroughly as to who would administer the anæsthetic, and what experience he had. He would not accept some one merely because they had done some favor for him; it would require something more than the conferring of a favor for the doctor to trust his wife or child in inexperienced hands. And why should we not do the same for our patient?

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[1] Doctor Packard's paper, entitled "Adenoid Operations," was read at the Sixtieth Annual Session of the American Medical Association held at Atlantic City, June, 1909.

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"Does the surgeon do the best for his patient when he employs someone to give an anæsthetic who has practically no experience? Is he giving the patient equal work for the anæsthetic that he gives in the work he performs? Would the surgeon trust some inexperienced operator to perform some difficult surgical operation while he stood aside and looked on, or have the nurse adjust a fracture, and expect as good adjustment as he would do himself? And yet with all this he would say that the anæsthetic is the easier of the two. There may be a difference of opinion, but this I will say: No surgeon is giving the patient just and proper treatment who does not employ an experienced anæsthetist, and he has no right to subject the patient to anything but the best obtainable."

From "The Trained or the Untrained Anæsthetist," by Hunter Robb, M. D. (of Cleveland, Ohio). Part of a symposium[1] on the Manner of Administering General

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[1] The entire symposium is published in *Surgery, Gynecology and Obstetrics,* May, 1909.

Anæsthesia, held by the American Gynecological Society, New York, April 21, 1909:—

"If any one of us were going to be operated upon and had time to do so, he would—at least I, for one, would—make three stipulations. He would, I think, demand (1) the best hospital facilities; (2) a skilled operator; (3) a skilled anæsthetist. But by what right do we insist upon for ourselves what we do not demand for our patients? Having chosen a good hospital and a good operator, why should we not be content to receive the anæsthetic from the youngest interne, or a fourth-year, or even a third-year student? I fear very much that hitherto we have been too apt to belittle the importance of this subject. When a patient dies upon the table from the anæsthetic, we are very properly shocked; but how about the later sufferings, or even fatalities from an improperly administered anæsthetic? Consider for a moment how often it happens that a newly fledged practitioner or a student is called upon to administer an anæsthetic to an unprepared patient—for instance to a man who has met with an accident just after a hearty meal, or maybe one who has a faulty heart or diseased kidneys. May it not make a great difference in such a case how the anæsthetic is administered? I firmly believe that many untoward accidents must be attributed to the fact that medical schools do not furnish proper instruction in this subject."

From "The General Administration of Anæsthetics," by J. M. Baldy, M. D. The President's address read before the American Gynecological Society, Philadelphia, May, 1908, and published in the *American Journal of Obstetrics*, July, 1908:—

"*The general administration of anæsthetics as performed to-day is the shame of modern surgery, is a dis-*

*grace to a learned profession, and if the full, unvarnished truth concerning it were known to the laity at large it would be but a short while before it were interfered with by legislative means—and properly so.*[1] In the traditions of our profession the poor receive as good service as the rich; so in the matter of anæsthetics is this true, only with this difference: in the first instance they both receive the best that is in us, in the latter they both receive the worst. Who of you is not familiar with the patient coming for a possible operation whose one dread is the approaching anæsthetic—a dread born of a past personal experience or the experience of a friend? Who of you is not familiar with the terrible struggle for breath so common to the etherizing room of the past, the congested, blackened face, the prolonged anæsthesia, the patient only partly relaxed, the delay in the operation, the difficulties of the manipulation after an operation began, the heart-sickness at a difficult and delicate operation made doubly and trebly so from the unnecessary chances of sepsis, hemorrhage and shock, the feeling of a patient lost from no lack of skill of your own, the slipping of a ligature and a secondary operation, or death, the immediate death on the table from failure of the heart, drowning due to inspired sputum, the vomiting on the operating table to the detriment of the operation, the prolonged after-period of naseau and vomiting to the great suffering and misery of the patient, the inspiration pneumonias and other pulmonary complications, the nephritis and urinary suppressions, all due in great part to faulty anæsthesia? How many deaths at the time of the operation, shortly after operation, or some days or weeks later, are due to the same cause? What relation does the anæsthetic bear to the large group of pulmonary complications reported from so many different sources, and what is its relation to the thromboses and embolisms which have in the past caused so much suffering and disaster? What of the fatty degenerations of the liver, heart and kidneys? Who can tell? This fact is certain, however: *more deaths following operations are due directly to the administration of the anæsthetic than the profession in the past has dreamed of.* Wherein lies the fault and where is the remedy? The present long-established and time-honored custom of having the anæsthetic administered in hospitals by the resident physicians, in private homes by an available doctor in the neighborhood, is to be condemned. The man who is able and ready to pay any amount of money for the services of the most skilful surgeon available has his life and the lives of his family unknowingly put at the mercy of a boy just from his books, with absolutely no practical knowledge of anæsthetics, and with less teaching. One has only to recall his own experience and feelings during the first few weeks of his apprenticeship at anæsthesia to realize how thoroughly at the mercy of chance was the survival of the patient and how utterly helpless he would have been had anything gone wrong. *Is it an exaggeration then to call such a condition a disgrace to the profession of medicine?*"

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[1] The italics are mine, throughout.

The remarkable paper from which I have just quoted, following upon the repeated warnings of Doctor Gwathmey and others, caused no small stir among both surgeons and practitioners, and the symposium held at the next annual meeting shows that President Baldy's fearless utterances are not to be without results. Indeed, there seems to be such a general awakening in the profession to the scandalous negligence heretofore shown towards this important branch of medicine, that I will hazard the opinion that the amateur anæsthetist will have been legislated into his proper place while the unrestrained novice in surgery is still hacking his way to fame or failure.

As Doctor Baldy says in his contribution to the symposium above mentioned: "It seems inconceivable that for so long a time the most important position in the operating-room, aside from that of the surgeon himself, should have been relegated to the hands of the most incompetent."

# CHAPTER X

## BACK TO MIDWIFERY

"The woman about to become a mother, or with her new-born upon her bosom, should be the object of trembling care and sympathy wherever she bears her tender burden, or stretches her aching limbs. The very outcast of the street has pity on her sister in degradation, when the seal of promised maternity is impressed upon her. The remorseless vengeance of the law, brought down upon its victim by a machinery as certain as destiny, is arrested in its fall at a word which reveals her transient claim to mercy. The solemn prayer of the liturgy singles out her sorrows from the multiple trials of life, to plead for her in the hour of peril. God forbid that any member of the profession to which she trusts her life, doubly precious at that eventful time, should hazard it negligently, unadvisedly or selfishly!" —Oliver Wendell Holmes, "The Contagiousness of Puerperal Fever."

There is, perhaps, no branch of medicine, as practised in our large cities, in which a more radical departure has been made from the methods of a generation ago than in the science and art of obstetrics. This applies particularly to certain hospitals where the giving birth to a child has come to be regarded as a pathological phenomenon, pure and simple. Hence the most ordinary cases of confinement in these hospitals are handled with the same elaborate care as surgical operations, and, indeed, this is precisely what most of them have become.

Now, in urging a return to a simpler *modus operandi*, I would not be understood as underrating the marvellous advance we have made in asepsis, and in the perfection of various devices that have removed at least some of the horrors that were formerly associated with difficult or abnormal labor. I simply desire to sound a note of warning against the exaggeration of this pathological and operative side of obstetrics, and to show how willing Nature is to perform her functions, hampered though she is by our so-called civilization.

I mention asepsis as one of the most important factors in advanced obstetrics, yet it is from our knowledge of asepsis that we refrain from the repeated vaginal examinations that were formerly resorted to and were undoubtedly responsible for much of the puerperal infection that prevailed. The up-to-date physician, regarding Nature's warning of "Hands off!" contents himself so far as possible with external examination. In this one instance, therefore, he and Nature have come to a perfect agreement—why they should clash the moment a difficulty is encountered must be left to the physician to answer. "We cannot say," writes Dr. A. Heger[1] (of Germany), "that the management of childbirth in a contracted pelvis has reached a very high degree of perfection when the obstetrician must choose whether to bore into the skull of the child, cut open the mother's abdomen, or saw the bones of the pelvis. And yet, with our present methods of obstetrics, we do not seem able to progress beyond these inhuman and crude procedures."

Generally speaking, then, the man who will let Nature attend to his case, and simply assist whenever a little assistance is necessary, is the real obstetrician—the one appreciated by the patient. He is the ideal family doctor who has helped hundreds of children into the world with a very low mortality rate. While well-informed and thoroughly abreast of the times, he is not carried away with the new and ultra modern methods employed by the specialists. Of all the branches of medicine the practice of midwifery is ordinarily the most simple, for Nature will take care of things in perhaps ninety per cent. of all cases.

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[1] "The Operative Era in Obstetrics." ("Die operative Aera der Geburtshilfe.")—*Beitrage zur Geb. und Gynaekologie* (Leipsic) XII, No. 2.

That this percentage is decreasing I will not deny—in other words that the American mother has been physically deteriorating—yet it is probably only a temporary setback, and hardly justifies the alarming statements of the over-specialized gynecologist or obstetrician. For example:—

> "It is a matter of general knowledge," writes Dr. Herbert Martin Stowe (of Northwestern University, Chicago),[1] "that the physical condition of woman has deteriorated during the past fifty years. The changes in the manner of living, the lack of physical exercise, and the method of dress in vogue at the present time, illy equip the pregnant woman for the coming trial of parturition. Obstetric dystocia is increasing to a marked degree. Delivery is rapidly becoming a pathological phenomenon."

Dr. Franklin S. Newell (of Harvard University), in an article entitled "The Effect of Over-civilization on Maternity,"[2] has given us a more detailed view of the conditions that endanger child-bearing, and far be it from me to minimize these dangers, even if I think Professor Newell has somewhat over-emphasized them. He says:

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[1] "Puerperal Sepsis."—The *American Journal of Obstetrics*, August, 1909.

[2] *American Journal of the Medical Sciences*, October, 1908.

" . . . Unless the standard of feminine accomplishments changes, and so long as girls (in school) are subjected to a strain which would break down the constitution of the average man, with their ambitions aroused not to fall behind their quicker companions, we must expect to see a constantly increasing difference between the women brought up to lead natural lives and those who belong to the over-civilized class. As time goes on, therefore, it is inevitable that unless some change takes place, the changed conditions which have arisen must become generally recognized, and a new obstetrics must be formulated to meet the new conditions.

" Those whose work takes them among the patients of the smaller communities, or the larger communities where over-civilization is comparatively of recent development, will unquestionably refuse to accept the truth of these observations; from their standpoint they are unquestionably correct, for never having had the opportunity to study such patients they naturally fall into the error of believing that such patients do not exist, and a man is naturally prone to disbelieve what he has never had the opportunity to see.

" If, therefore, we admit that in certain communities a class of women has been developed who are unfit to bear the burdens of pregnancy and labor, but who nevertheless are subjected to the strain, the question must arise as to what methods of procedure in the care of these patients will give the best chances of a favorable result. Distinct differences of opinion will of necessity arise between those in the medical profession who admit the development of this unfit class and those who deny its existence; and even among those who recognize present conditions, the problem of how they can best be met is far from settled. The ordinary duties which are incumbent on the obstetrician are to conduct an obstetrical case to a successful conclusion with a living mother and a living child; but the point is often lost sight of that the obstetrician has a further duty, which is to bring his patient through her troubles in such nervous and physical condition that she will be able to assume the functions and duties which properly belong to her after her convalescence is completed. . . . It seems to me that the time has come when we must recognize the fact that abnormal conditions, such as have developed in our older communities, must be met in an abnormal way if we are to do our full duty to our patients."

Doctors Stowe and Newell are not alone in their pessimistic outlook—practically all the leading obstetricians of the cities preach and practise the same theory, till midwifery as it was understood a few decades ago seems to them as remote as mediæval astrology.

These views, nevertheless, are combatted, and in no uncertain voice, by the practitioner of the type described above, whom I have designated as the ideal family doctor. And not only do they combat the theory by argument, but they adduce facts and statistics from their own practice to show the excellent results that follow from treating Nature throughout as an ally rather than an enemy. Nor will they accept the answer that old-fashioned midwifery methods may do among healthy country women but not in the cities, for some of their leading exponents are city practitioners, though the majority have undoubtedly acquired their experience in the towns and rural sections.

"If we country fellows," writes Dr. T. H. Line (of Marquette, Nebraska),[1] "were to practise obstetrics like some of our great big brother city obstetricians would have us, it would be necessary to have a paraphernalia wagon follow us when we go to our obstetrical cases."

Doctor Line reports that in twenty-seven years he has handled "something like three thousand cases of confinement at full term or within a month or two," and adds: "I have not, up to this time, had a single death as a result of parturition or from abortion and . . . no sepsis of any importance." Such records as this are by no means exceptional, although they are invariably attacked by city specialists who, as a rule, can make no such favorable showing. In contrast to the average country practitioner, however, Doctor Line admits the free employment of the forceps, which, he contends, are a great service, if carefully used.

Here we have the whole matter in a nutshell. Despite the atrocious use of the forceps and other instruments, and the incalculable injury to both mothers and infants that has resulted from a premature interference, or from unskilful technique, the forceps are, or rather, might be, one of the blessings of civilization. It is not any particular instrument or remedy or procedure that I am attacking in these pages, it is the unscrupulous or unskilful doctor who wrongly employs such agents.

"The forceps," writes Dr. J. K. Quigley (of Rochester, New York),[2] "have been called the bloodiest of obstetrical instruments; they may be, but need not be. I would not minimize the seriousness nor dangers of these instruments, but in experienced hands, with clean-cut indications for their use, forceps operations are not the mutilating procedure pictured by some."

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[1] "Obstetrics in Country Districts"—a letter contributed to the (Philadelphia) *Medical Council,* December, 1907.

[2] "The Obstetric Forceps."—*New York State Journal of Medicine,* August, 1908.

Dr. Adam H. Wright (of the University of Toronto), after making the surprising statement that "the majority of obstetricians consider that the induction of labor is a serious interference with Nature's work, involving some danger"[1]—would that it were so in the leading American cities!—says:—

"If, however, we can perform the operation in such a way that it causes no danger, or at least very much less danger than the prolongation of the pregnancy, to the patient, we might justly conclude that early interference after term is not only justifiable but advisable. Those who have given up the barbarous methods adopted in so-called *accouchement forcé* are now inducing premature labor by simpler means and with the results of a few years ago."

And so an anonymous contributor to the (Philadelphia) *Medical Council*,[2] who wrote under the caption "Medical Falsehoods":—

"We hear of the physician who has attended several hundred cases of confinement without having used forceps. It is possible, I dare say, but hardly probable that some of these cases did not call for instrumental interference. Statistics and men of ripe experience show us that in a certain proportion of cases it is necessary to use instruments. The physician who leaves all his cases to Nature, in my opinion, places too much hardship on the real mother, who, I believe, should be relieved as much as possible of the suffering incident to childbirth. We are not animals, and our advancement along lines of civilization has brought more pain to our women in their hours of travail. The physician who leaves all his cases to Nature is wrong, and I fear at times does so from lack of understanding the use of what medical science has given us to relieve suffering humanity."

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[1] "Induction of Labor at Term."—*American Journal of Obstetrics*, August, 1909.

[2] The (Philadelphia) *Medical Council*, October, 1907.

All of which is elementary, both to the profession and laity alike. Let us therefore turn to the other phase of the question and consider a few testimonies on the misuse of the forceps, and the altogether too prevalent *accouchement forcé*, which Dr. Wm. M. Robinson, the well-known editor of the *Critic and Guide*, defines as " the forcible hastening of a slow but sure labor that the obstetrician may keep a dinner or theatre engagement."

Dr. John Edwin James, Jr. (of Philadelphia), in a paper entitled " The Management of the Third Term of Labor," read before the Homeopathic Medical Society of the State of Pennsylvania and published in the *Hahnemannian Monthly,* December, 1906, says:—

" There is a tendency on the part of too many physicians to grasp at means that will shorten the number of hours their cases are in labor, presumably to conserve the strength of the patients, actually to allow them to finish with the tedious job and return to numerous other professional obligations."

Dr. Alexander Isaacson (of New York), in a letter upon the "Abusive Use of Forceps in Primiparæ," contributed to the *New York Medical Journal*, July 9, 1910, puts the matter thus forcibly:—

> "Putting aside the case where the use of the forceps is truly indicated, we come to the many cases in which haste and greed only are the paramount issues, and the forceps is applied to the detriment of the patient. A woman in labor is very readily influenced and convinced to allow the use of the forceps; particularly primiparæ, who are so impatient as to concede almost anything in order that their pains may be lessened; it is also a very common idea among the laity that primiparæ should be delivered with instruments, and many physicians will take advantage under these circumstances.
>
> "I believe it is very unfair and unjust, non-professional, for a physician to apply the forceps simply because he is too busy and cannot wait for the natural forces to act, or because he is envious of his brother physician and desires to lead in the percentage of forceps deliveries performed. A forceps delivery, even in the hands of the most competent, is, nevertheless, an operation which should not be taken too lightly; it surely does not add to the safety of the mother or child; and to subject a patient to this ordeal for selfish reasons only, as is often done, constitutes, in my mind, a criminal act."

Dr. Charles S. White (of Washington, D. C.), in a paper entitled "Cerebral Injuries in the New-born," read before the Washington Obstetrical and Gynecological Society, November 6, 1908, and published in the *American Journal of Obstetrics*, May, 1909, presents some most instructive facts. Although he believes that "instrumental delivery, especially the low or medium forceps operation, deserves less blame than is generally ascribed to it," he instances many gruesome cases pointing to carelessness or criminal haste on the part of the obstetrician. "It has occurred to me," he observes, "that in our zeal to deliver a living child we have lost sight of the fact that the ideal condition is not fulfilled unless the offspring is healthy and has the right to live. Physically, surely all men are not born equal, and it is often a pelvis or forceps that shapes our ends."

In a later portion of his paper, Doctor White says:—

> "It is at least interesting to note the relation of forceps to mortality of the fœtus. From a compilation by Dr. Julian M. Cabell, of the records of Columbia Hospital from 1874 to 1904, comprising 5,760 cases, forceps (high, medium, and low not always specified) were applied 236 times, and in twenty-four of these cases no mention is made of the child's condition or even whether it survived; but considering such cases as having recovered, I found that twenty-four died within a month and thirty-four were still-born, a mortality of 10.2 per cent. and 14.9 per cent., respectively, or 25.1 per cent., collectively. I would not interpret these statistics to mean that one-fourth of the infant mortality is due to forceps, because unquestionably the fœtus was dead before delivery was attempted in some cases, while in others death may have been purely coincident with and not dependent upon instrumental delivery. But these figures indicate that forceps make an impression upon infant morbidity and mortality and must be reckoned with."

Discussing intercranial hemorrhage of the new-born, one of the commonest accidents in the careless use of instruments, he quotes some startling statistics from a German authority,[1] showing a mortality of seventy-eight per cent., and of the " remote " condition he is no less pessimistic:—

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[1] Seitz: *Munchener med. Wochenschrift,* LV, No. 12,601.

> " Recovery from the acute condition does not warrant a roseate prognosis. Seeds have been sown for slower but irreparable changes. In the wake of intercranial hemorrhage is left the defective intellectuality of the epileptic, the pervert, degenerates, imbeciles and idiots. It is beyond dispute that milder cases may completely recover, but in the pronounced type the prognosis of the ultimate result must be purely conjecture."

" We may be said to be in the midst of a revival of *accouchement forcé*," writes Dr. W. E. Fothergill (of Victoria University, Manchester), in an article entitled "A Review of Recent Work in Obstetrics, *Accouchement Forcé*, and Vaginal Cæsarian Section," contributed to the *Practitioner* for April, 1905. Concluding, Doctor Fothergill says:—

> " It is notorious that, in spite of the teaching of the schools, the forceps is often applied through an incompletely dilated cervix, and delivery is often attempted and carried out before the dilatation is complete. Also, when turning has been done before the cervix is fully open, the temptation to deliver is often too strong, and the child is pulled, head first, through an undilated canal. The disastrous results of the laceration and dislocation of the pelvic floor so caused are only discovered at a later date. The recent papers on dilatation and *accouchement forcé* paint these occurrences—they are not accidents—in such lurid colors that it seems probable that the whole profession will at last realize that delivery must not be attempted until dilatation is complete. The forceps is an instrument for ending the second stage of labor, and not for use before the com-

pletion of the first. . . . In short, it is an atrocious blunder to end the second stage of labor before either Nature or art has ended the first."

Dr. P. Horrocks, in "The Midwifery of the Present Day," contributed to the *British Medical Journal*, March 10, 1906, after emphasizing the danger of infection from frequent examinations before or during labor, states:—

"It is little short of criminal to terminate normal labors as quickly as possible by the use of forceps or manual interference. It may be true that with all metal, boiled, aseptic forceps, with aseptic hands and parturient parts, a child may be delivered without setting up sepsis. But unless there is good reason, it is quite unjustifiable. There is no such thing as a painless labor, and no known method of rendering it painless without injury."

Sir J. W. Byers contributed an article to the same journal,—one of the most influential in the English-speaking world,—for August 7, 1909, entitled "Progress in Obstetrics," the keynote of which is that the ideal to be aimed at is not merely a living mother and a living child, but rather a living, healthy mother and a living, healthy child. Doctor Byers cites the statistics of the two largest Irish maternity hospitals (the Rotunda Hospital of Dublin and the Maternity Hospital of Belfast), which are exceptionally good, and comments thereon as follows:—

"Such splendid results have been brought about by recognizing that in at least 75 per cent. of the cases labor is a natural process not needing interference, and that its tendency is to prevent infection, and that our duty is to follow and aid it, and to interfere only when the resources of Nature fail to protect the interests of mother and child. The uncalled-for use of the forceps, early rupture of the membranes, douching—unless under very special circumstances—and the improper management of the third stage of labor are things of the past in properly conducted maternities. By the thorough application of the most minute surgical cleanliness as regards patient, nurse and doctor during labor and the puerperium; by the adoption of Crede's teaching, that internal examination of parturient women should be altogether avoided or restricted within the narrowest possible limits (it can be well replaced by external examination) and by the immediate suture of any laceration occurring during the process of labor, these excellent results are possible of attainment."

Such testimony could be multiplied indefinitely, but I think I have submitted enough to convince the reader that a huge tragedy is being enacted through the ignorance or incompetence of those who should possess the very highest qualities both as physicians and as men. In fact, simple as is the practice of obstetrics, there is probably no branch of medicine to-day in which ignorance and irresponsibility play so large a part.

The young doctor lacks experience and patience, and the old doctor violates the fundamentals of asepsis, and in the one case in ten, or nine, or eight, or whatever the percentage may be, of those who have to be operated on or assisted with instruments, he fails to understand the serious consequences that may follow from the neglect of a lacerated birth-canal. The average practitioner, moreover, is too busy and the specialist, if I may so express it, is over-specialized and usually in too big a hurry. There seems no consensus of opinion as to what is just the right thing to do, and often the man who has sense enough to let a normal case alone, has not knowledge or courage enough to recognize an abnormal case demanding the promptest operative interference. In a word, there are many doctors who put the whole burden on Nature and there is a host of specialists, or would-be specialists, who make every case a surgical one. It is but another example of the dilemma of the " frying pan and the fire."

In referring to specialists, I meant, of course, honest specialists, capable or at least conscientious men whose mistakes are due to an ill-focussed view of everything that relates to their specialty—men, in short, who are carried away by the " fads and fancies " of their profession. Besides these, however, are a number of so-called specialists who are simply unspeakable villains and murderers, men whose actions are so cold-blooded and remorseless that conscience in them seems dead. If the head of the fœtus is unusually large or the pelvic outlet unusually small, and everything points to a hard forceps case necessitating no little vigilance and responsibility, such a man is in the habit of resorting to a craniotomy—puncturing the skull and delivering a dead child. And this he can do with absolute impunity, since he will invariably state that it was done to save the life of the mother. That is, an obstetrician in this Twentieth Century may, if he chooses, from the most selfish motives, and with no regard for the distress of the hopeful parents, deliberately murder a living child. Truly the cloak of " specialism " may cover a multitude of sins.

I met a graduate of a certain famous lying-in hospital recently, who, in referring to Doctor J., one of the leading obstetricians in that institution, pronounced him " the worst scoundrel he ever saw." When I asked him what he meant, he replied: " Doctor, I have seen him do unnecessary craniotomies over and over again. It's monstrous for a man to kill babies, just to show students how brutal he can be."

The doctor of whom he spoke has acquired the unenviable reputation of performing this horrible operation quicker than any other obstetrician in the city, and his unnecessary Cæsarian operations are notorious.

Not long ago I had a discussion with a practitioner of thirty years' experience who had confined hundreds, probably thousands, of women. He assured me that he had used the forceps very little and had never had an occasion to do a craniotomy. He was intelligent and ambitious, and yet a conservative practitioner. Doctor J., the specialist just referred to, will do perhaps twenty forceps cases a week and three or four craniotomies, and have a mortality rate which is appalling. At the hospital there are no questions asked. The superintendent does not bother about it, and if the annual report shows an unusual mortality, it is explained by the assertion that as a rule only difficult cases are sent to the hospital. Nor does the report give the subsequent history of the forceps victims. They are delivered of a live infant, it may be, but little or no thought is given to the partially healed lacerations or to the little one so cruelly handicapped at the threshold of life.

The following case will illustrate the criminal methods of these perverted " specialists."

Doctor M. is one of the attending obstetricians of a large hospital in a large city. He is a very skilful man and nearly all of his cases are operative cases. On one occasion he was preparing a paper to read at an important convention of physicians on modern Cæsarian operations, and, of course, he wanted to collect as many cases as possible, preferably his own. Consequently every pregnant woman who had a slightly narrow pelvic outlet, or was in any way abnormally developed, presented to his specialized vision a possible subject (or victim) for Cæsarian Section. A Cæsarian Section, by the way, is an operation in which a child is taken out of its mother's womb through the abdomen.

On this particular occasion a patient was brought into the hospital and referred to Doctor M. for examination. She had been in labor twelve hours and there were no signs of progress. Considering that this was her first baby, and also that she was a very frail woman with a small pelvis, Doctor M. showed marked interest. Nevertheless, he said he wanted to be "particularly careful" not to go wrong in his diagnosis. After what he considered a thorough examination, however, he was sure it was a transverse position (in which the child lies across the womb), and that the head was "enormous." Satisfying himself upon these important points, he called the husband and other members of the family and explained to them that the patient could not possibly have her baby in the natural way, first because it was in an abnormal position, and secondly because the head was too large. There were only two things to do; one was to kill the child and take it away piecemeal; the other was to perform Cæsarian Section, which was a very severe operation both to patient and infant.

He had spoken to the patient and she had told him she wanted her baby at all hazards. Of course, then, he was willing to operate if the family also consented, and he thought he could save the life of mother and child.

Believing everything that he told them, the family consented, and so he gave orders, allowing them all to see the patient for a few minutes before she was prepared for the operation. Leaving the hospital to see two other patients and to get some " special instruments," he instructed his house surgeon to have everything prepared for the operation in two hours.

During his absence, however, and while the house staff and operating-room force were getting things in readiness, the patient was making progress. Frequent pains caused the house surgeon to wonder, and finally to recognize the unmistakable signs of impending delivery. In less than one hour from the time our specialist had left the hospital there was born a bright, healthy little chap of six and one-half pounds, who had given his mother very little pain but lots of anxiety before his appearance.

There remains little more to tell. Doctor M. came back with an assistant and a bag full of instruments, only to be met on the front steps of the hospital by the husband and the house surgeon, smoking their pipes and shaking hands with each other.

" Meddlesome obstetrics " is one of the curses of civilization, and with surgery in general and the particular abuses that will be considered in the next chapter, calls for the most drastic reform. No one is readier than the writer to pay homage to the reputable obstetrician who meets a grave crisis with the skill and fortitude of a master, and by his energy and courage saves mother or child, or both, from what seems certain death. But if this skill and mastery produce an ill-balanced temperament that misinterprets the normal processes of Nature, and views everything connected with child-bearing in a pathological light, then I say better far a return to the crude reign of the midwife.

But the obstetrician need not be abolished. Let him once look beyond the narrow bounds of his " specialty," let him be humanized, or socialized if I may so express it, and his patchy science and faulty " ethics " broadened out, and he will himself reject the over-specialization that he so confidently practised, and return to midwifery, a humble disciple of Nature whom it is his honor to serve and occasionally to assist.

# CHAPTER XI

## CRIMES AGAINST POSTERITY

"To ensure a sanitary marriage it is imperative to establish a quarantine station before the marriage license window, over whose gate should hang this legend: *No Health Certificate, No License!*"—Dr. Albert H. Burr.

"The effects of gonorrhœa on the female generative organs have been so destructive that no successful contradiction is feared when the belief is expressed that no disease of modern times has caused so much indirect mortality, mutilation and suffering, both mental and physical, as gonorrhœa."—Dr. Joseph Tabor Johnson.

Though the above title is open to the charge of ambiguity, I have chosen it as best expressing modern society's attitude of criminal indifference toward generations yet unborn. And as this book is a criticism of the present standards and practices of the medical profession, not of the public at large, it follows that by largely ignoring the public's share of responsibility an unjust emphasis may seem to be placed upon the shortcomings of the doctors. This, of course, while not my intention, is almost unavoidable, just as the elimination of the economic aspect of the problem gives a disproportionate view both of the ethical and the physiological.

The duty of the medical profession toward posterity is threefold: First, to preserve human life and health; second, to perform the services of midwifery; and lastly, both by instruction and by treatment, to promote the highest sexual standards. In this latter division should be included the important science (as yet so little understood) of eugenics, or race culture; but this subject is such a vast one that I must reluctantly pass it by and hold to my unpleasant task of condemnation and exposure. I say reluctantly, because it is largely owing to the investigations of medical men and biologists that race culture has been rescued from the province of speculative philosophy, and rendered a practical, though as yet undeveloped, science, the importance and possibilities of which no one could be so bold as to estimate. All honor, then, to the disinterested men who are devoting their lives to this momentous problem, and dishonor to those who not only contribute nothing to the welfare of humanity but are themselves active factors of a physical and moral retrogression.

As the obstetrician's shortcomings have been set forth in the preceding chapter—and surely no greater crime against posterity could be perpetrated than the selfish, ignorant or reckless practices that I have instanced—we come naturally to the domain of the gynecologist, that branch of medicine and surgery which more than any other flourishes and fattens upon inhumanity and vice. For were it not for the blunders of the obstetrician, the selfish endeavors of modern women to avoid motherhood, and the criminal carelessness of the vicious brutes who communicate venereal diseases to their innocent wives, gynecology would be one of the least lucrative branches of the profession. In a word, therefore, the increased need of the gynecologist is in no small degree a sign of national decadence, physical and moral.

Of all the sins, both of omission and commission, with which I charge the physician, perhaps he is least culpable in the matter of the spread of venereal diseases, for here he is suddenly confronted with a law, or rather with a variety of laws, regarding professional confidences, all more or less strict and inelastic, and evidently framed with the idea of atoning for the scandalous license that prevails in nearly every other branch of modern medicine. Having liberty to maim and kill pretty much as he chooses, which, if he is a man of any principle, he regards with abhorrence, he comes suddenly face to face with a "Thou shalt not," obedience to which, at times, means little less than his connivance at the most monstrous injustice.

Let it be distinctly understood that in ordinary cases I am in favor of the strictest, most scrupulous observance of professional confidences, and I do not think that the sacredness of the patient's trust in his physician could well be exaggerated. Even the New York State law forbidding a physician on the witness stand to disclose facts learned in the secrecy of the sick chamber is good in its intent. Where the iniquity of this law, and in fact of nearly all such laws, comes in is the lack of discrimination, the equal protection of innocent and guilty. When the secret concerns only the patient himself we all agree—physician and layman alike—that it should be held inviolate, but if the health or very life of another is involved, the doctor bound to silence becomes in reality, whether willing or unwilling, an accomplice in crime.

For instance: A woman may consult him with the purpose of inducing him to perform a criminal abortion. He is proof against her solicitations, whereupon she declares that if he will not commit the child murder she will get some other doctor to do it. He believes that the woman is in earnest, and knows that she can easily obtain the services of an abortionist, respectable or otherwise. Should this physician report the case to the authorities and have the woman put under bonds to refrain from murdering her child? If in his conscience he believes such an act to be murder, then assuredly it is his duty to do all in his power to prevent the crime. If he neglects this duty he then becomes an "accessory before the fact," even though he salves his conscience with the assurance that he is obeying the law of "professional confidences." Thousands of honorable physicians have been placed in this position, not once, but often. Has a single one of them ever reported such a case to the authorities? If so, I have yet to learn his name.

But it is in the domain of venereal diseases that the most serious cases arise. The problem has been widely discussed in medical societies and journals, but up till now has not received the attention it should in the lay press, or in popular *decent* medical books written for the laity. Among periodicals, however, I must except the *Ladies' Home Journal*, which has conducted a most commendable educational campaign on this vital subject.

Let me now briefly illustrate the horrors of the venereal plague and the disastrous results that may, and so often do, affect the innocent wife and the unfortunate offspring in consequence of the protection afforded by those who should be the guardians of the public health and welfare.

A man having gonorrhœa or syphilis, let us say, consults a physician. He is engaged to be married. The date is set. He is either not willing to have it postponed or he fears that to suggest such a thing would arouse suspicion on the part of his fiancée. The physician assures him that he cannot possibly cure him in such a short time, and that if he persists in marrying he will surely infect his bride with the foul and loathsome disease.

The man, however, is obdurate. Neither reason, nor honor, nor pity can move him. Time passes, and at last it is the day before the wedding. What is the physician's duty under these circumstances? Should he bow before the fetish of "professional confidences," and allow this loathsome beast to be united at the altar to a pure and innocent girl? Or should he act the man, the protector of a defenceless and trusting womanhood, and expose the scoundrel's unspeakable vileness of body and mind before it is too late?

In New York, were he to adopt the latter course, he would find himself liable for damages to the outraged patient. In Massachusetts it would probably be the same, though professional confidences are not there regarded as quite so binding. Nevertheless, in Massachusetts and, I believe, in all the other states, neither the common nor the statute law defines the infecting of a woman with a venereal disease as anything worse than a misdemeanor. In some states it is not even that.

Thus, if a physician in almost any state in the Union should decide to prevent such an iniquitous marriage, he must bear in mind that he is not preventing a legal crime, whereas he *is* rendering himself liable to the law for violating his obligations to his infamous patient. For a man rotten with venereal disease to marry a pure woman is no crime, but for a doctor to expose such a villain is both dishonorable and illegal. Could a greater travesty of morality and justice be imagined?

Let me give a concrete case that recently came to my notice. A certain physician was consulted by a young man suffering from an acute venereal disease. He was engaged to be married, and had contracted syphilis from a prostitute since his engagement. The wretch refused to consider for a moment the doctor's advice to postpone his marriage for about two years. He even threatened personal violence if the doctor interfered in the matter. This doctor was a cautious and law-abiding man. He decided that his responsibility in the matter ceased after he had given the proper advice and warning, and so observed the usual professional secrecy. The marriage took place at the appointed time. The bride was a robust, handsome young woman, well known in society. A few months later she was a victim of severe syphilis, which broke out all over her body. Her hair fell out in handfuls, her mouth became a mass of foul sores, and before the first anniversary of their wedding that attractive bride was a repulsive invalid, her beauty gone, her constitution wrecked and her hopes of motherhood shattered for life.

Let us contrast the perfectly legal and "ethical" course adopted by this practitioner with the courageous stand taken by Dr. John C. King (of Banning, California). I quote from a letter from Doctor King to the *Medical Record* of February 6, 1909:—

> " . . . I for one have reached the point where, under certain circumstances, regardless of damage suits or professional ostracism, I will not protect syphilitics or gonorrhœics.
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> "A young man was under my care for primary syphilis which rapidly developed secondary symptoms. I had given him complete instructions regarding the danger of communicating his infection to others. While mucous patches were present around his anus and in his mouth he married a pure and beautiful girl of twenty

years. Six months later she was the victim of malignant syphilis. The divorce court gave her freedom from the man who contaminated her, and also made him free to infect another pure girl.

"A young woman of lovely character, whom I had cared for from babyhood, asked me if it was safe to marry a young man who was also my patient. I replied yes. Two weeks later, in the effort to test his potency before marriage, he acquired gonorrhœa. In spite of strenuous opposition he married the girl during the acute stage of his disease. I have since operated upon his wife.

" In a similar case another physician notified the girl's parents on the morning of the wedding day, thus preventing the marriage. This doctor had previously endeavored to induce the man to postpone the ceremony, but without avail. He then threatened to expose him and finally did so in spite of assurance of bodily injury. I honor the doctor.

" A young woman whom I knew to be pure brought to me her lover on account of sore throat. Their wedding day was approaching. The man had secondary syphilis; his throat was badly ulcerated. He refused to postpone the marriage. I then told him to leave town within 24 hours or I would explain his situation to the girl. He left. Subsequently the girl married a decent fellow.

" In cases where venereal disease is necessarily contagious I will protect the girl and not the man; first, of course, endeavoring to induce the man to afford the needed protection. Most men will do so, but all of us have met instances where they will not."

The statistics that have been compiled by those who are investigating and endeavoring to combat this frightful evil are most significant. They justify, nay, they demand, that every engaged girl, or her parents, should insist that her lover submit to a careful physical examination by her own family physician. Such an examination would not always be infallible, but it would greatly help to safeguard the woman. No decent, clean man would object to this, and of any man who did, it might safely be set down that he had something to conceal. A girl should refuse to marry a man who could not show a medical certificate stating that he is apparently free from venereal or other diseases. Of course it must be admitted, and with shame, that there would be many doctors prepared to write any kind of certificate desired, if well paid for it. And again there are others who might mean well enough but would not be competent to make such an examination. Still where there is one medical knave or fool, there are, let us hope, two or three who are honest and capable, so that it would be a great safeguard to a girl if her fiancé were required to show her father a medical certificate of health.

It was my intention to go into this momentous question much more thoroughly, and to summarize the attempts that have been made in various states, particularly in Iowa, to stem the fearful tide of venereal infection, but space forbids. Suffice it to state that according to Bulkley, "New York City alone presents annually 50,000 people newly infected with gonorrhœa or syphilis," while Doctors Valentine and Townsend[1] state that "the people infected actively or otherwise with these diseases are so numerous that the 120,000 physicians of the United States and Canada would not, even if all became venerologists and applied themselves to these examinations alone, have time to care for those of their patients whose ailments are of an uninfectious character."[1]

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[1] "Iowa's Endeavor to Control Gonorrhœa and Syphilis." A letter contributed by Dr. Fred C. Valentine and Dr. Terry M. Townsend to the *Medical Record,* January 10, 1909.

The subject is a vastly complicated one, but when the above facts become better known, and it is generally understood that a large proportion of the women who are operated on by the gynecologists are the victims of this scourge, there will surely be a public awakening followed by the most drastic protective measures. Then it will be both "ethical" and legal for the physician to act in the interests of the mothers and children, and this particular evil will be regarded in its true light as one of the most heinous of crimes.

I wish for the honor of my profession that I could plead any extenuating circumstances for the widespread practice of abortion. Here, however, we find an utter disregard for the law even in those states which have the most carefully devised enactments. The criminal code of New York State, for instance, as well as of various other states, makes criminal abortion or the killing of a child *in utero* a felony, the penalty for which is imprisonment with hard labor for a term of years. And yet to-day the abortionists of every large city are practising their nefarious trade with complete impunity. Why is it that the prisons are not filled with these criminals who are corrupting what was once an honorable profession? I think the answer lies in a name—because the successful abortionist calls himself a gynecologist. And so again we find specialism a cloak for cupidity and crime.

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[1] Since writing this chapter I ran across the following in a letter from Dr. F. G. De Stone to the *American Journal of Clinical Medicine,* August, 1908:—

"If there ever was a question, on which we as physicians should try to get legislation, this one of genito-urinary disease should cause us to come together, regardless of school affiliations, and fight the common foe. In the October *Clinic,* under 'Therapeutic Nuggets,' are given statistics that would almost make a dead man sit up and think. 'Eighty per cent. of blindness, and seventy per cent. of abdominal pelvic operations are due to gonorrhœa, from which ninety per cent. of all men suffer at some time, and eighty-five per cent. of cases occurring in married women are contracted innocently from their husbands.'

"This is the damning charge. Is there any one so narrow that he will not admit that our methods and our laws are inadequate?"

I have also received a copy of Dr. William L. Holt's remarkable paper on "The Venereal Peril," selections from which will be found in Appendix H.

Criminal abortion, no matter by whom practised, is the felonious destruction of a living embryo, and whenever an act of this kind is committed by a physician he should remember that he is a murderer in every sense of the word, and ordinarily a despicable type of murderer at that, since he practises his dastardly profession for the money there is in it. It must be admitted, however, in all fairness, that with many it is a most distasteful operation which they perform, not for the fee involved, but because otherwise the valuable patronage of the family would be lost.

To illustrate what the family physician has to contend with, I will cite a case that was recently related to me.

A young married woman became pregnant, but did not wish to have her child. She consulted her physician and requested him to perform an abortion. The latter, who was an able, upright man, refused to commit the crime. He was a personal friend of her family, and his interest in the woman was therefore greater than if she had been a stranger. He reasoned, advised and admonished to the best of his ability, but all to no purpose. The rash young woman insisted that she would have the operation performed, and that was all there was to it. The doctor, however, persisted in his refusal. She then told him that if he would not help her there were plenty who would, only she would prefer to have her own physician, as she would feel safer in his hands than with an unknown doctor. He declined to be won over by this appeal, and after a final remonstrance the young woman left his office.

On the following day the doctor called on a lady whom he knew to be in the confidence of his other consultant. He enlisted her services to dissuade her friend from the step she was contemplating. She promised to do her best, but told the doctor frankly that she knew her advice would be ignored. He admitted that he was of the same opinion, and that his main object in calling was to safeguard his young friend as much as possible if she persisted in her foolish and wicked purpose. Owing to the strong personal friendship he had had for her when she was a girl he felt that he could not remain passive and let her fall into the unscrupulous hands of an ordinary, crude abortionist. For that reason, and that only, he would now place in her friend's hands the names of three reputable doctors who, though they performed abortions, were, he knew, expert gynecologists who operated according to the most approved medical and surgical principles.

He made the lady promise, however, not to tell her friend that he had done this much for her, as he did not wish her to think that even for friendship's sake he would so far seem to condone her offence.

The lady read the names of the three expert abortionists with some surprise. Instead of obscure or unknown names she saw those of prominent men. All three ranked high in the medical profession of that great city, while one of them, at least, enjoyed more than local fame.

The operation was performed, the child was murdered, and the mother, at last accounts, was doing well.

To what extent criminal abortion is practised we shall never know, but that it has increased at a most alarming rate in recent years is acknowledged by every medical authority and sociologist in the country. A study of the census and of the birth rate affords sufficient evidence. In a notable article that appeared in the *Delineator* for November, 1907, Mrs. Lydia K. Commander, who has pursued her investigations for many years, presented some startling facts. Probably 2,000,000 homes, she estimates, are without a child and have never had a child.

"A little more than one hundred years ago," says the editor of the *Journal of the American Medical Association*,[1] commenting on these figures, "it was calculated that children formed one-third of the population of the country. According to the last census there were about 18,000,000 children in the country, which is less than one-fourth of the population. This difference does not seem to be much, but in cold figures it amounts to 7,000,000 children. Of course in the meantime many adults have been admitted as immigrants, and this has somewhat lessened the proportion that should exist in the matter, but there are at least 5,000,000 additional children that would be with us if anything like the old family life of our great-grandmothers' times still survived." Continuing, the editor says:—

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[1] November 23, 1907.

"The interesting consideration is with regard to the next generation. . . . When a people become so individualistic that they do not care to assume the burden of rearing and caring for children, they have reached a stage in evolution that is apparently undesirable. It is true that it is they themselves who are the principal factors in bringing about this elimination, but then Nature always uses just this method. One might look for some great cataclysm in the natural order to get rid of an undesirable class of the population and might wonder how it could be brought about. As a matter of fact it works out so quietly that no one notices it much, and least of all are they who are affected by it aroused to any concern as to its real significance. Natural selection thus automatically removes the over-selfish from the scene and the drama of life continues with new characters."

I think the editor has overlooked the acute economic distress that has spread over this land of liberty and plenty, which is undoubtedly responsible in part for these conditions. But his charge of selfishness is certainly true of the leisure-class, and it is this very class who have corrupted the medical profession, who are in turn corrupting the people of lesser means till abortion has come to be all but a legitimate branch of medicine.

I say this advisedly. Williams[1] stated nearly a decade ago that "a conservative estimate would indicate that about every fifth or sixth pregnancy ends in abortion," and as far back as 1893 the *Medical Record*[2] estimated that "only one out of every ten thousand cases of abortion is detected by the authorities," at which rate it calculated that New York alone had "at least 80,000 abortions" in that year. It has since been estimated by Justice John Proctor Clark that the cases in this city exceed 100,000 per annum.

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[1] Dr. John Whitridge Williams's *Text-book of Obstetrics*, edition of 1904.

[2] June 3, 1893.

Of course the profession has not become entirely shameless, and the avowed abortionist, that is, the fellow who advertises his skill in women's irregularities, etc., is entirely without caste. In the case of these rascals I do not understand why prosecutions are not successful in those states that have passed anti-abortion laws, for their advertisements are displayed in many of the leading papers and they have neither the cloak of a specialty to shield them nor the professional support of their fellow practitioners. Yet they flourish in every city from the Atlantic to the Pacific, and it is quite exceptional for one of them to come to grief.

With regular practitioners and reputable specialists the excuses and subterfuges resorted to are as varied as they are effective. Performance of abortion is everywhere permitted providing a woman has advanced kidney trouble or heart failure, or has a contracted pelvis, or, in short, is in any condition which, if the mother were to have a child, would jeopardize her life. These numerous provisions give the gynecologist ample scope, and if a doctor is anxious to get his share of such lucrative work, all he is obliged to do is to call in an assistant who confirms any diagnosis that is made. This makes the whole proceeding legitimate, so that, with a previous diagnosis and consultation on record, there is nothing to fear should the case turn out badly.

Here we have one reason for the wonderful popularity of the curette and of the painful and by no means simple curettage of the womb so frequently resorted to. The clever doctor, who would as soon produce an abortion as bandage an injured finger, calls in a professional accomplice, and after an apparently deliberate consultation they finally decide to do a curettage (or emptying the womb by scraping it) for the benefit of the all too willing patient. After the operation is over they assure the family that the patient never could have had her baby on account of this or that ailment, and wind up by hazarding the opinion that should she become pregnant again another curettage will be necessary.

Discussing this phase of the question, Dr. A. B. Davenport (of Columbus, Ohio), in a paper read before the Academy of Medicine of his home city, May 29, 1909,[1] says:—

> "The disorders of pregnancy are often seized upon as an excuse for interference on the part of the physician. This one is a case of emesis requiring prompt emptying of the uterus; this is a case of threatened Bright's disease on account of a suspected or real trace of albumen in the urine. Here is a case of contracted pelvis which has been ascertained and demonstrated 'by rule of thumb,' giving rise to visions of impossible delivery. Suppression of the menses from 'exposure to cold at the last menstrual period' is a very common excuse advanced why 'something must be done,' and, of course, this 'something' takes the form of medication with abortifacients, mechanical massage, the introduction of the uterine sound, or the dilation of the cervix and curettage of the uterus. No matter what the conditions are, there is only one line of treatment to

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[1] "Criminal Abortion." Published in the *Lancet-Clinic,* September 28, 1909.

institute, and that is the prompt emptying of the uterus. While some of the conditions enumerated may be sufficient to justify interference, they are too often made to serve as an excuse for what is simply criminal practice. In a fairly wide experience of more than nineteen years in general practice, I have yet to encounter a single case in which I would be justified in terminating pregnancy for any of the reasons I have indicated."

In apportioning the blame for the alarming spread of this evil, he says:—

"I would have you understand that I do not think the commission of this crime is by any manner of means confined to those outside the pale of legitimate medical practice. I know, and you also know, it is not. Stress is here laid upon the part taken by the legalized practitioner of medicine in the commission of this crime. In the discussion of this subject he is generally not considered a factor of sufficient importance to justify including him among those guilty of this particular act. The midwife, the irregular practitioner of medicine, the purveyor of abortifacient drugs—anybody but he—are charged with the act. In my experience and opinion he is the most active of all in committing the crime, and to name him is to confess our professional shame, something too many of us hesitate to do; hence he escapes mention. These are the men we must reach in our own profession, and after we have done so we may rest assured the law will take care of the others engaged in criminal work."

This is apparently a rather sweeping statement, yet it is none the less true. Addressing the Section on Obstetrics and Diseases of Women at the Annual Session of the American Medical Association held in Chicago, 1908, on "Criminal Abortion in its Broadest Sense," Dr. Walter B. Dorsett[1] (of St. Louis), the chairman, said:—

"Self-induced abortion, or abortion produced by a fashionable or fad doctor, is, as we know, a fruitful cause of the horrible pus cases in which we are now and then called to operate. This fad doctor is one with a lucrative practice, and is often 'the lion' at social functions. He it is who empties the uterus in cases of emesis gravidarum without first racking his precious brain in trying all recognized remedies and methods to check the vomiting. He it is who finds so many cases of contracted pelvis where it is utterly impossible to do anything but an early abortion to save the woman's life. He it is who finds so many cases of retention of menses, that require dilatation and curetment. He it is who finds the urine 'loaded with albumen,' necessitating an immediate emptying of the uterus to prevent death from Bright's disease. Such men and women prostitute the profession of medicine and should be exposed."

Instances of this kind have repeatedly come to my attention, and it has even been my unfortunate experience to see a member of the New York Academy of Medicine perform several such abortions, all upon selfish women who were able to pay him well, not only for a successful "operation," but for a plausible pretext that would silence any objection on the part of husband or family. Charity cases with him are on an entirely different footing, and I very much doubt if he ever yielded to the entreaties of a forlorn girl to end her pregnancy unless there was a substantial fee accompanying the request. In short, this physician practises his infamous profession almost solely among the rich and solely for the handsome fees he gets.

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[1] See Appendix H.

I have purposely refrained from mentioning the case of the young girl, who, through another's fault and her own weakness, faces the terrible ordeal that our self-righteous society imposes upon the unmarried mother. Here, not unfrequently, we encounter a double tragedy, the fall of the girl from her state of innocence and, equally far-reaching in its consequences, the fall of the sympathetic young doctor who yields to her entreaties and performs his first criminal operation. For, once the physician yields to temptation, no matter how disinterested his motives, his whole life is changed. Unknowingly he has begun, morally, to deteriorate, and the repetition of the crime (in time for the mere money there is in it) becomes all but inevitable.

Discussing this phase of the subject, Doctor Dorsett says:—

> " The average student is not impressed by precept or example with the enormity of the crime, and coming into practice, often a poor young man, is first shocked when he is asked to procure an abortion; but after the wolf has howled at the door for a time he yields to the temptation and often drops into the practice. Far from the Hippocratean teaching of the ancients have our colleges wandered by their utter disregard as to the morals of their students."

To kill a child *in utero* is infinitely worse than to practise euthanasia. One is the destruction of a potential man or woman, an unfolding life whose character and destiny only the Creator can foretell; the other is the snuffing out of a life which has all but faded away. Physicians surely lose patients enough without deliberately taking up a form of murder as their regular practice. God knows it is bad enough to lose a case by accident, but when the destruction of life is made a legitimate branch of the profession and a wholesale slaughter is begun, it is time for us to call a halt and invoke a sentiment that shall sweep over our country and make this dastardly crime against posterity a crime here and now. The ending of uterine life and even the wanton destruction of cellular life is opposed to the spirit of the race and should be earnestly fought against, particularly by organized medical bodies who have it in their power to mould public opinion in these matters almost as they will.

The reform must come in two ways: First by uniform, drastic legislation in every state and territory, making the abortionist a criminal who can be extradited as easily as any other outlaw, and secondly by educating the public so that fœticide will become as abhorrent a crime to society as murder or rape or arson.

The following digest of the laws in effect two years ago (which is recent enough for our purpose) was carefully prepared by an able Western lawyer at the request of Doctor Dorsett, and shows how much has to be done before a uniform or approximately uniform code can be expected from our ignorant and apparently indifferent legislators. The questions are from Doctor Dorsett, the answers from the lawyer:—

"Question 1.—Is the woman herself guilty of any crime? In how many states is she and in how many is she not?

"Answer.—In nine states a woman who solicits, submits to, or performs an abortion on herself is guilty of a felony. In seven states the above offence is a misdemeanor, and in the remaining states and territories, viz., thirty-five, the woman is guilty of no crime.

"Question 2.—What is the charge and penalty for giving away, selling or advertising abortive drugs and drugs or appliances to prevent pregnancy?

"Answer.—The charge is a felony in but twelve states and territories out of fifty-one, and the penalties vary from imprisonment for from one to ten years, and in some states a fine ranging from $20 to $5,000. In twenty states the offence is only a misdemeanor. In thirty states and territories there are no laws on this subject.

"Question 3.—What is the charge and penalty as dependent on the age of the fœtus?

"Answer.—In four-fifths of the states and territories the age of the fœtus is immaterial.

"Question 4.—What is the effect of death of the woman operated on as to charge and penalty?

"Answer.—If the death of the woman results from the operation, in eighteen states and territories out of fifty-one the crime is murder and the punishment is death or imprisonment for life. In six states it is murder in the second degree, and the penalty is imprisonment for life or for a term of not less than three years.

"Question 5.—May the offending physician or midwife have his or her license revoked?

"Answer.—The license may be revoked in only fifteen states out of fifty-one. In thirty-two states there are no laws that can be invoked successfully for the purpose of depriving a physician of his license for this cause. In other words, he may successfully murder indefinitely and go unmolested.

"Question 6.—Is a physician who gives subsequent treatment allowed to testify, or is his information privileged?

"Answer.—There is only one state, Missouri, in which it is provided by statute that a physician is allowed to testify as to facts learned while attending a woman on whom an abortion has been performed."

But, after all, public opinion—a strong moral sentiment—can accomplish more than all the laws in our statute books, and in the discussion that followed Doctor Dorsett's notable address, educational rather than legal measures were emphasized.[1] This also is the recommendation of Doctor Davenport, from whom I have already quoted, who concludes with these impressive words:—

"Make clear to both sexes the immorality of the crime of abortion. Teach them that from the hour of conception the child is a spiritual being and that its destruction is murder in every sense the term implies. Let a girl believe that the greatest and noblest duty of a woman is to become a mother; to bring into the world a living soul, to guide, train and direct the growth and development of that boy or girl, is a moral and spiritual duty second to nothing else. When she is imbued with this grand conception of her mission in life she will not soil her hands and soul with the blood of her own body through that of her child."

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[1] The paper read by Doctor Dorsett and its discussion by prominent members of the American Medical Association meant a distinct advance for the progressive medical men of this country. I wish it were possible to reproduce the entire symposium, for such it really was; but this being impracticable, I have selected the most interesting part of the discussion, which the reader will find in Appendix I.

# CHAPTER XII

## THE GYNECOLOGICAL PERVERT

It seems almost a platitude to say that the elemental instincts and passions of the primitive man are constantly manifesting themselves to-day, even in men of culture and high mentality, and that one of the most deplorable of our inherited traits is the tendency to kill, injure or destroy. In many of us this destructive tendency is largely latent, or has been suppressed by other traits less savage and ignoble; but in some it has been allowed to develop to such a degree that the character becomes essentially brutal, and then we recognize a degenerate or moral pervert.

Perhaps the commonest expression of these prehuman proclivities is the infliction of pain, injury or mutilation upon other living beings, animal or human. This is forcibly illustrated by our delight in war, either in actual participation or in reading of the exploits of others. Of course, in warfare the sacrifice of life is partially justified on the higher ground of national welfare or honor; nevertheless, a psychological analysis of any army will show less fervor of patriotism than this inherent, primitive lust for blood and mastery. This is further exemplified in the history of slavery; and everyone is familiar with the atrocious barbarities that until recently marked the conduct of our educational, charitable and penal institutions. Indeed, even to-day, under the noonday glare of this Twentieth Century, there is altogether too much heartlessness and brutality on the part of those in authority in our prisons, asylums, hospitals and so-called "homes," toward the helpless inmates whom we profess to love and succor. And in the domain of medicine and surgery, particularly the latter, as has been shown in preceding chapters, there has grown up a spirit of cruelty and heartless indifference to human suffering that makes one wonder if we are yet a civilized people. This, of course, is the one logical point of attack upon animal vivisection.

But selfish cruelty and indifference to the needs and sufferings of others is not necessarily degeneracy—in fact, it is more often a sign of faulty education and brutal or narrow environment than of anything fundamentally inhuman or prehuman in those who exhibit this trait. But there is another and more subtle cruelty which is often hidden under a pleasing exterior and must be attributed to heredity rather than to education or environment. This also manifests itself in the injury or mutilation of living beings, particularly the human form, and where such a tendency exists in a man of intelligence and apparent refinement, we are confronted with the lowest and most dangerous type in society—the pervert.

Such creatures display a psychopathic condition almost unthinkable to normal and healthy minds, and I would shrink from discussing this unpleasant subject were it not that perversion plays a part in surgery, and especially gynecology, never before suspected, finding therein a license and security possible in no other legalized profession or occupation.

The reader is no doubt aware of the investigations that have been made in this field by the great alienists, Krafft-Ebing, Havelock Ellis, Forel, Lombroso, and others. These eminent men of science have torn the veil from certain diseased states of the human mind, particularly in the matters of sex. Though their work as pioneers in a hitherto uncharted region is necessarily faulty and, at times, contradictory, it has unquestionably led to the foundation of a great science.

Of course, long before these painstaking observations were recorded, most men who had any knowledge of the world were aware of the existence of such perverted tendencies in exceptional cases; but the majority of respectable women knew nothing whatever about these things. Now, while it is not recommended that women—or even men—should read the scientific books dealing with sexual perversion, it is necessary for their protection that they should know of its existence and of the danger to which they are exposed if their medical adviser should be one of this depraved class.

*Sexual perversion in surgery*—I am not aware that the attention of the scientific world has been called to this lamentable phase of degeneracy, but it is time that the facts were known not only within the profession but by the public at large.

All have seen gruesome reports in the newspapers of cases of rape where the ravisher has afterwards mutilated his victim's body, sometimes exercising the most fiendish ingenuity in his maniacal fury. In the South, particularly, criminal records teem with such cases, and it is not too much to state that certain criminal perverts of this description, notably negroes, would satisfy their lust even though they saw waiting for them just across the body of the victim the stake and fire. Only recently in Berlin a number of little girls were found thus outraged in one day. A slightly different aspect of this perversion is where the criminal satisfies his lust by mutilating the female animals on a stock-farm.

Although many of these revolting acts are traceable to creatures of the lowest type, it is undeniable that instances of extreme perversion are often found among men of supposed culture and refinement, which simply means that the intellect has become a servant to lust, devising new and subtler forms of sex gratification. At heart he is the same, a savage degenerate, whom a wise society would no more permit at large than a dangerous lunatic or a leper.

Now let us suppose the case of a young man, intellectual, talented, and perhaps with great aptitude in surgery, but nevertheless at heart a sexual pervert. He begins practice, and soon acquires a reputation as a skilful surgeon. But he feels, stirring within him, sadistic tendencies which he cannot or will not repress. He looks about him for a means of gratification that will be well within the law, and his search is soon rewarded. He becomes a gynecologist, a specialist in the diseases of the female pelvis. Soon he has gained the confidence of a host of feeble-minded or ignorant women, some of whom are ill, many of whom are simply hypochondriacs—and on one and all of whom he has absolute license to operate just as much or as little as he chooses.

He begins, of course, by using the curette. It is a simple procedure, from his standpoint, to lacerate the inner membrane of the uterus, and though often of great and lasting harm to the victim, the curettage is long his favorite operation. But soon he looks longingly at the abdominal cavity. McDowell, the father of American surgery, performed successful ovariotomies without the aid of anæsthesia or our modern knowledge of asepsis. Why cannot he start in on an ovariotomy? The great surgeon under whom he studied perhaps taught that most young women would be better off without the constant menace of motherhood and had invariably removed the ovaries of those who came under his knife. And so, with this damnable sophistry on his tongue, he becomes proficient at unsexing his women patients who come to him with their petty troubles, and is never so happy as when cutting out ovaries. Except when a uterus can be removed. That is an even greater gratification. A clean sweep of the pelvic organs—a mutilated, unsexed woman—what a tribute to his skill as a surgeon!

At last, in the satisfaction of a great reputation, he casts a proud glance backward at his long list of sterilized women. What a benefactor he has been! It is a strange coincidence, though, and sometimes he wonders at it, that a large percentage of his "successes" have become emaciated invalids or hopeless, nervous wrecks within five years of the beneficent operation. But this, of course, is a mere coincidence and must be so regarded.

A most significant fact in connection with ovariotomy is the indifference displayed by reckless operators when the ovaries of elderly women are in question. I have seen men remove perfectly normal ovaries from young women, and carefully put back in the abdomen diseased ovaries of women who have passed the change of life. How explain such inconsistency except on the hypothesis herein advanced of sexual perversion on the part of the operators?

A peculiar variant of this procedure is seen, I am told, in the operative technique of Doctor X. of Chicago. This man is conceded to be a skilful surgeon and an "expert gynecologist." When operating for any reason, on young women, he often cuts off the two labia minora (the small folds or lips lying just within the labia majora). Why does he do this? When asked for his reason for so remarkable an act his reply is rather vague, and at best unconvincing. At the present writing other gynecologists do not seem to have discovered the peculiar advantages of this manœuvre, though doubtless he already has obscure imitators. Priority must therefore be granted to Doctor X., and whatever his reasons, personal or professional, for such mutilation, it must remain, for the present at least, his own exclusive method.

Does the gynecologist of this type understand his own case? Possibly he does, but it is more likely he is self-deceived. Could he once honestly try to analyze his motives he might come to a realization of the shameful truth, but this seems the very last process of which his mind is capable. When these gentlemen are questioned as to the ultimate effect of the removal of the ovaries, they will usually reply that those operated on are better than women left as nature made them. When referred to the increasing number of women who have become neurasthenics after unsexing, they reply that this is not true. Of course, it would be expecting a degree of heroism incompatible with the frailty of human nature to expect even a reputable gynecologist to admit that a large percentage of his patients have become mental or physical wrecks, so he would plead ignorance of such results or lie. He usually lies, blandly, convincingly.

The reader has already made the acquaintance of Doctor K.,[1] but I fear that I did him a slight injustice. I referred to his methods as not quite modern, entirely ignoring his record in gynecology. Here, at least, he is thoroughly up-to-date, as the following case will well illustrate:

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[1] Chapter VI.

Miss L. M., a beautiful young woman and a social favorite, consulted Doctor K. on account of abdominal pain which occurred during her menstrual periods. She was engaged to be married to an estimable young man, and had every reason to look forward to a happy future and a home blessed with children. But she had reckoned without her medical adviser, who, when he had duly questioned her—probably with a preconceived theory—shook his head and gravely announced that she had severe ovarian disease which demanded immediate operation. Now what was the poor girl to do? Here was the supposedly learned opinion of an authorized physician and surgeon. In these days of widespread knowledge it is regarded as a sign of ignorance to question the opinions of those presumably authorities in their special branch of art or science. Miss M. and her mother were educated, sensible people, and therefore were willing to be guided by the advice of this wise and skilled doctor. So the unfortunate young woman bravely consented to an operation, and trustingly placed herself in his hands.

Doctor K. opened the abdomen by a large incision, but to his surprise found nothing that could account for the symptoms except the mere presence of the ovaries. To be sure these did not seem diseased, but then they were *ovaries*, which to his distorted mind suggested only the abnormal or pathological. Nevertheless, he paused. Perhaps he remembered, while there was still time, the patient's splendid womanhood, her approaching marriage and the sacred privilege of maternity. However that may be, Doctor K. was a gynecologist first and a man afterwards. The obvious thing to do, reasoned the gynecologist, was to remove while he might these offending and—potentially at least—dangerous organs. So with sickening thoroughness he cut out every trace of both normal ovaries, and then, as an afterthought, removed a perfectly normal appendix.

The patient recovered from the actual operation in a surprising manner. Indeed, the period of rest and careful diet during convalescence brought about a temporary improvement in her general condition. Moreover, she was never fully informed of her unsexing, although Doctor K. dutifully told her husband of it after the marriage.

In a short time, however, this poor victim of the gynecological mania began to pay the penalty that outraged Nature imposes, and within two years she had become a confirmed neurasthenic. By the third year she was suffering from frequent hysterical attacks, and at last accounts her condition was getting still worse. There is little comfort and less hope for husband and wife in that dreary and childless home.

In contrast to this lamentable tragedy—for I know not what else to call it—let me give the case of Miss A. F., who, at twenty years of age, also about to be married, developed symptoms similar to those of Miss M. Now it happened that Miss F.'s mother and sister had both been operated on by a specialist for so-called diseased ovaries, and when she consulted him it was a foregone conclusion what the answer would be. Her fears were realized; the doctor diagnosed her trouble as diseased ovaries, and advised immediate operation.

But Miss F.'s fiancé and her brother-in-law, who were fortunately informed of the proposed operation, got together and decided that another specialist should be consulted before anything further was done. After going over the matter thoroughly with the second doctor, it was agreed that the operation might be performed under these conditions: that the removed ovaries should be given to the patient's family after the operation to be taken to an accredited pathologist, unknown to the operator, for examination. If the report showed that the surgeon's diagnosis was correct he should receive his large fee, but if he were wrong and the ovaries proved to be healthy he was to expect nothing—except, possibly, a lawsuit. Upon hearing these conditions the family surgeon was highly offended and flatly refused to operate.

The young woman's trouble soon disappeared and shortly afterwards she was married. She is now the mother of two healthy children, and for several years has not had one day's illness.

It will doubtless be urged by my medical critics that the danger of operating on a snap-diagnosis has long been recognized, and that instead of making a clean sweep of the pelvic organs, up-to-date gynecologists have become much more cautious and conservative. "No longer," we are told, "do the surgeons who report the most radical operations on the female generative organs receive the greatest recognition." For which, if true, let us be devoutly thankful!

Reviewing the practice of gynecology for the last two decades, Dr. George H. Mallett (of New York) says:[1]—

"When in most cases it was found that the tubes and ovaries were diseased, or were thought to be, then came immediate laparotomies, performed during the acute stage of the disease, and followed by a ruthless sacrifice of organs and a high rate of mortality. A considerable number of these patients, suffering from suppurative diseases, who survived the removal of their appendages, still were not relieved until the whole uterus was also removed. The rule was then formulated that when the tubes and ovaries were removed, the 'emasculated' uterus should also be taken out. This rule is observed by many operators to-day. Then the pendulum swung the other way and so-called conservative surgery took the place of radicalism, and while many tubes and ovaries were saved, others were allowed to remain in such a diseased condition that a subsequent operation was required for their removal."

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[1] "The Operative Treatment of Pelvic Infection."—The *American Journal of Obstetrics,* August, 1909.

Dr. J. Thomas Kelly (of Washington, D. C.) also takes the modern system to task for ultra-conservatism, although he admits the horrible stage of recklessness that formerly prevailed. "Some years back," he writes,[1] "after the advent of gynecology as a specialty, and when men wholly untrained in the pathology of the female sexual organs removed those organs for symptoms frequently neurasthenic, one might see in almost any hospital numbers of normal organs sacrificed. . . . So rabid were gynecologists to do surgery that there was nearly a wholesale wiping out of gynecological therapeutics."

Nevertheless, he contends, "while this is true now with some surgeons who do pelvic work without the proper training, the general aim among gynecologists is to endeavor to save all healthy organs or parts of organs." And the remainder of his paper is taken up with the disastrous results of this over-caution and conservatism.

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[1] "How Far is the So-called Conservative Pelvic Surgery Conservative?"—The *American Journal of Obstetrics,* July, 1909.

This position may, in Doctor Kelly's city, be well taken, but I am sure in the country at large the tide has by no means so noticeably turned that we can deem American women safe in the hands of the average gynecologist. And the reasons are apparent. Conservatism in surgery takes more time, more judgment and frequently more skill than the slash-away methods so commonly resorted to. Foolish women, moreover, partly through ignorance of the dangers to which they are subjecting themselves and partly through selfishness, urge, if they are being operated on, the complete removal of the ovaries as a safeguard against further trouble, and the possible dangers of motherhood. And lastly—and I make this statement advisedly—while gynecology or surgery as a science may show every indication of progress, in its application by the polluted hand of the pervert there is just as certain a retrogression. Temporize, apply massage and other palliative measures, make gently explorative operations, try at all costs to preserve the sacred functions of wifehood and motherhood—are these likely to be the methods of the hardened brute who through greed or pure perversion has unsexed hundreds of healthy women? If the reader could see as I have seen the methods employed by degenerates of this type and could observe their facial expression when the fountain-head of motherhood has been reached and the vicious strokes are given that doom the unconscious patient to a life of disappointment and suffering—if American wives and maidens, I say, could once witness such a shameful and disgusting sight, there would be an end once for all of this revolting phase of gynecology.

I shall never forget the case of a New York lady who came to my office one day complaining of pains in the calves of her legs and in the thighs and pelvis. She was a woman of perhaps too much wealth and leisure, yet it did not take me long to dismiss the thought that she might be a hypochondriac. On the other hand, I was unable to find any serious disorder in either the abdominal or pelvic region to account for the mysterious yet persistent pain. Finally I forced myself to the conclusion that hers must be a case for a specialist, and knowing my friend Doctor E. to be both honest and skilful I sent the case to him. But Doctor E. was no more successful than I was, and beyond assuring her that there was no uterine or ovarian trouble he did little to afford relief.

The impatient husband now took his wife to another gynecologist, demanding a proper diagnosis and a swift and permanent cure. So the obliging doctor did as he was ordered, discovered a grave pathological condition in the pelvic region, decided that it arose from diseased ovaries, and had no difficulty in securing their consent to an ovariotomy. Incidentally, he collected a fee of two thousand dollars.

In about a year I saw the husband again. His wife, he informed me, had undergone a long convalescence and had undoubtedly benefited both by the rest and careful dieting and by the relief of mind caused by the assurance of this great gynecologist that her trouble was over for all time. But since getting about again, to their surprise and vexation, she began to notice a return of the same mysterious pain—in the calves of her legs, the thighs and the pelvic region. And so I was asked once more to undertake the case.

I consented, and requested the gentleman to bring his wife to my office, secretly determining to spare no pains to unravel this mystery that had baffled two such well-known specialists. And when the lady came, even before she sat down, the whole trouble was as clear as daylight. She was suffering from flatfoot—the arches of both feet being affected—and to this and this only was due the widely distributed pain. An order for two Whitman braces proved all that was necessary to remove every vestige of the trouble, but I shall never forgive myself that I did not discover all this a year earlier. Had I done so, I should have saved her from the greatest blight that can fall on a woman's life.

I am aware, as I stated at the outset, that many of the exposures made in these pages, and perhaps this chapter in particular, may lead to a certain amount of harm, inasmuch as it may dissuade the timid sufferer from consulting a doctor at all, or from going in time to render a cure possible. If such an interpretation has been put upon my vigorous protests against the prostitution of a noble and most necessary profession, I am truly sorry. Scathing as I would make my denunciation of the unspeakable fiends who gratify their depraved instincts under the cloak of a respected and legitimate calling, I would not be understood as for one instant minimizing the work of the conscientious gynecologist. Owing to the widespread and lamentable abuses outlined in the preceding chapter, the specialist in the pelvic diseases of women has come to occupy an increasingly important place in medicine and surgery, and to an honorable minority is due much constructive and educational work toward the amelioration of the abnormal sex conditions that we have come to associate with modern womanhood.

Indeed, I heartily agree with Dr. Channing W. Barrett of Chicago that the general operator is seriously in error in thinking that he can evade this highly specialized branch of surgery and successfully perform the most delicate operations that pertain to it. I do not agree with Doctor Barrett in calling the exclusion of gynecology as a specialty from many of our hospitals "*the* crime of gynecology,"[1] since I wish to appropriate the term for the lamentable conditions herein outlined, but it is unquestionably a matter of no little importance and calls for immediate reform. There is no question, moreover, that in real cases of ovarian or uterine disorders delay in consulting a reputable physician may lead to the gravest consequences and be clearly responsible for many drastic operations that must ultimately be resorted to.

There is much to be said on this subject in which all advanced practitioners and surgeons are more or less agreed, but I have simply touched on it to prevent, if possible, a misunderstanding of my position in regard to the practice of medicine by incompetent and unscrupulous men. I would advise every woman who has any serious irregularity to consult a physician, but I would at the same time warn her of the tremendous importance of choosing one who is at once honest and up-to-date, a doctor—if she can find him—whose knowledge has not run away with his common sense and whose ambition or lust to operate has not destroyed his manhood. If this chapter serves to protect one woman from the toils of the mercenary or perverted "expert," it will not have been written in vain.

It must be admitted that many conscientious authorities deny that any particular disorder or danger results from this unsexing, and contend that the patient has "simply lost her power of reproduction." What a wealth of hidden irony in that word *simply!* The consensus of expert opinion, however, is opposed to this, and all advances in neurotherapy tend to prove that her entire life and character has been changed. The former position is well set forth by Dr. Emil Novak (of Baltimore), who concludes his paper on "The Hormone Theory and the Female Generative Organs"[1] with the following generalizations:—

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[1] Doctor Barrett contributed a noteworthy article under this heading to the *American Journal of Obstetrics* for May, 1909.

> "The time has passed when healthy ovaries were ruthlessly sacrificed to cure dysmenorrhœa, obscure pelvic pains, etc. It is true, of course, that the saner and more conservative methods of the modern gynecologist were literally forced upon him by a realization of the futility of the irrational and mutilating measures of former days, as well as by the awakening of the surgical world to the fact that it is only rarely in accordance with the principles of true surgery to remove tissue that is not the seat of disease, especially when such tissue can be shown to possess a definite and useful function. A restraining influence of no little importance has therefore been imposed upon us by the knowledge that the ovary, in addition to its well-known function of ovulation, plays another more subtle rôle in the processes of the woman's body. At the same time, it is only fair to present the other side of the picture also. Such experimental work as I have described, as well as innumerable clinical observations, have shown that however important the hormones of the female generative organs

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[1] Read before the Baltimore City Medical Society, February 19, 1909, and published in *Surgery, Gynecology and Obstetrics,* September, 1909.

may be, they are not by any means indispensable to life, or even usually to comparative comfort, and hence, from this standpoint there would seem to be no physiological basis for such ultra-conservative operative measures as some would advise. While it is impossible to generalize concerning a question which is essentially an individual one, as regards both surgeon and patient, it would seem that radical conservatism, as it has been called, is scarcely less commendable than that unreasoning radicalism, pure and simple, which will not brook the restraint that knowledge and reason would impose."

Dr. C. M. Rakestraw (of Savannah, Georgia) ably presents the other side of the subject,[1] and I only regret that I cannot quote from his article at greater length. He says in part:—

" In a series of ninety-one cases, all of which had been dismissed from the hospital as cured, Dr. Mumford, of Boston, found 33 per cent. psychic failures. Dr. Howard Kelly, in a study of a series of anatomical successes, found 37 per cent. psychic failures. With the disastrous results following the destruction of a woman's generative system in view, all manner of methods are being devised to save these organs and preserve their functional integrity. In the past the saving of life seemed to be surgery's highest aim; the greatest surgeon was he who could, with rapidity and skill, dissect among vital organs and delicate structures, carry a case along the very brink of eternity and avoid death. The individuality of his patient was sunk in the pathology of a disease, and instead of being a creature of intellect and emotions, was a case of this or that disease, the woman with the tumor, the woman with a tube. It is no wonder surgeons impressed the world with the idea that their highest purpose was to cut skilfully and to make wonderful advances in anatomical and biological science. But now we are beginning to advance our biological findings to the higher functions of the human economy, we are beginning to realize that the purpose of the human frame is to house a 'Great Within.' In saving tubes and ovaries our object is something more than merely to save the sexual delights of life or the office of procreation; in saving a uterus we are attempting something more than the preservation of the menstrual function or the prevention of a premature menopause. We are saving the intellectual life, the emotional life, and are regulating the sensory nervous system so that the various gland functions will not be interfered with."

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[1] "The Prophylactic Treatment of the Psychical Results of Surgical Diseases." Read before the Georgia Medical Society, Savannah, Georgia, December 17, 1908, and published in the *American Journal of Obstetrics,* February, 1909.

Dr. John E. Cannady (of Charleston, West Virginia), at the twenty-first annual session of the Southern Surgical and Gynecological Association[1] pointed out the advantages of waiting and giving Nature a full opportunity in cases of infected Fallopian tubes. There were numerous valuable methods of treating uterine pathology without the removal of both uterus and disease. It was seldom necessary or advisable to remove the ovaries.

Dr. George H. Mallett, in the paper from which I have already quoted, concluded with these words:—

"The patients suffering from pelvic infection are usually young women, and the loss of their ovaries and tubes is of considerable importance to them as the symptoms of artificial menopause are usually pronounced and the atrophic changes frequent; but the ultimate result in this class of cases is fortunate as compared with some that come under observation after the uterus has also been removed. In them senile atrophy occurs to such an extent that sexual intercourse is prevented or interfered with or they are rendered miserable by a senile vaginitis that resists all forms of treatment. They become mentally morbid and are unhappy in their domestic life. One of these patients will do more to prejudice the laity against surgery than all that could be written or said by mental healers or osteopaths.

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[1] Held at St. Louis, December 15-17, 1908.

"At the present time these unfortunates are not so numerous as in former years. If by yearly surgical intervention disease may be arrested and tissue and organs saved, then an important step in true conservatism has been made."

No better indication could be given of the practical agreement of the leading surgeons and gynecologists on this question, at least physiologically—for it must be admitted that there is much divergence, as yet, on its moral aspects—than the session of the American Gynecological Association from April 20th to the 22nd, 1909. The discussion of the sterilization of women related largely to the complications of Cæsarian Section, but the remarks of many of the members ranged over the entire problem and are most interesting.

In a paper entitled "Sterilization in Cæsarian Section,"[1] Dr. John Pollack (of Brooklyn, New York) strongly advocated the retention of one or both ovaries whenever possible. He said:—

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[1] This and the excerpts that follow are taken from the report of the transactions of the Society as published in the *American Journal of Obstetrics*, June, 1909.

"In the course of thirty or more sections in which the writer has participated, but two ovaries have been found diseased; each of these was a dermoid cyst which had become incarcerated in the pelvis and had acted as the obstruction to the progress of labor, which was the indication for the abnormal delivery. There is no reason why extirpation of one or both ovaries should be done in the course of hysterectomy, any more than when removing the uterus for a fibroid tumor. While there is a slight technical difficulty in leaving the ovaries when the uterus is extirpated, we well know the physical and psychical advantages to the patient by retaining the ovarian secretion."

Dr. Charles M. Green (of Boston), who read a paper entitled "The Justifiability of Sterilizing a Woman After Cæsarian Section With a View to Preventing Subsequent Pregnancies," was even more positive and emphatic. I should like to quote at considerable length from Doctor Green's contribution, but the following utterance leaves no one in doubt as to his position:—

"It is not likely to be requested that the husband be sterilized, and yet the request would be quite as reasonable as that the wife should submit to sterilization. Would it be justifiable to sterilize a woman in order that she might become a prostitute without the possibility of becoming pregnant? We know that we may not commit murder or homicide; we know that suicide is a moral and statutory offence, and that attempted suicide is punishable. If it is morally and legally wrong to destroy human life, is it not also immoral to destroy any human function? Do not some of us remember the well-merited contempt visited upon men, who, to avoid service in the War of the Rebellion, mutilated themselves in a way to prevent acceptance by the examining surgeon? *Qui facit per alium facit per se;* and if it is culpable for one wilfully to kill or mutilate the body, it is also culpable to cause or allow the same purpose to be effected by another."

Among the many who took part in the open discussion perhaps Dr. George Gellhorn (of St. Louis) made the most apt rejoinder to the advocates of sterilization by reminding them that there was a much simpler way of sterilizing the male, viz., by vasectomy. This operation could be done in a minute or two under local anæsthesia and it did not leave a scar. There were able-bodied men present, and yet how many would be willing to have vasectomy performed? He thought we should be a little more charitable and not do unto others what we did not want done unto ourselves. He denied the right of any one physician to sterilize any woman; only for grave reasons should the operation be acceded to, and then it should only be done by consultation with one or more physicians.

And so I might quote from scores of well-known surgeons and gynecologists pointing out the dangers both physical and psychical resulting from this indiscriminate and largely unnecessary unsexing of women. That no one has charged a certain minority with actual perversion is either a reflection on the intelligence of reputable members of the profession, or is but another illustration of the strange misapplication of our code of "ethics," which would shield one of the lowest and most dangerous types of degenerate that our civilization has produced at the cost of the health and happiness of the innocent women whom it is our duty and privilege, both as men and as physicians, to shield and protect.

If women could only be made to realize these facts; if only the laity as a class were not so hopelessly ignorant of the rudiments of anatomy and physiology, there would be fewer of these gynecological crimes. The astonishing indifference of intelligent men and women on this subject seems to depend, first, on ignorance of physiology, and secondly, on external appearances. As a woman cannot see these organs she is apt to minimize their importance.

We must bear in mind, in this connection, a point often overlooked, viz., that culpable "authorities" are frequently upheld in their statements as to permanent benefit derived from ovariotomy by their unfortunate and hopeless victims. Many of these feel keenly the loss of their womanhood, but shame closes their mouths; they would not let others know what they have become, and thus either keep silent or indorse the lie of the operator.

All physiologists know that when males and females are castrated in infancy they do not develop like normal individuals. The form of the body is neither that of man or woman, but an approximation of both. The male's voice remains high and shrill. In both the mental development is usually very defective.

Thus it is evident that the presence of these glands is of vital importance in the formation of body and mind. Such unsexed individuals are often mere repulsive wrecks of humanity.

If there is any essential difference in the practice of useless and harmful ovariotomy and criminal abortion, the perverted gynecologist is, if anything, the greater criminal. He completely sterilizes the woman and deprives her of the possibility of future motherhood, whereas the abortionist simply deprives her of a single child. The ovariotomist, moreover, deliberately deceives his patient as to the necessity of the operation and its remote effects, in order to gratify his avarice and perverted cravings. The abortionist does not deceive. His candor is complete and shameless. He merely panders to the selfishness and wickedness of the woman. She knows just what she wants, and she gets it. Such a transaction, in contrast with the former, seems almost respectable. Let us discard our genteel phrases and euphemisms and have a square deal all around. If abortionists are criminals, then so are many gynecologists. The statutes should be revised, and the needless removal of the ovaries or uterus, or any unnecessary mutilation of the female generative organs, should be classed along with criminal abortion as a felony, punishable by heavy fine and a term of years in prison. Thus, and thus only, can we conserve the life of the nation and discharge our sacred duty to posterity.

# CHAPTER XIII

## HOSPITAL ABUSES

"National health and vigor depend in a very great degree upon the arrangements made for the treatment of the sick. This is just as true of adults as of children. The interests of society to cure the ailments of the latter are . . . obvious; their right to care and healing is absolute, and the injury to society caused by neglect is serious and prompt. But the case of adults is not in principle different. A sick worker is a burden, instead of a benefit, to society at large. The labor by which he adds to the wealth and convenience of the world is suspended; he has to be doctored, physicked and maintained by the labor of others, until such time as he is able again to take his place in the social machine. It is, therefore, the interest of society to shorten as much as possible the period of incapacity of every sick man who is of any use in the world, and to restore him expeditiously to his normal position."—Sir John E. Gorst, M. P., on "Physical Deterioration in Great Britain," in the *North American Review.*

I THINK the statement can hardly be challenged that the civilization of a city or a state may be judged by the efficiency of its hospitals. These institutions are the outcome of the most generous human impulses, the desire of the strong and prosperous to care for and comfort the suffering and the needy.

It is an inspiring sight to walk through the well-kept wards of a great hospital, to see the long rows of comfortable beds with their convalescing occupants, the splendid operating rooms in which are gathered from all the world the latest instruments and apparatus for the treatment and cure of surgical conditions, and, hardly less admirable, the well-arranged laundry and spotless kitchen. Equally impressive is the discipline of the fine corps of nurses and attendants, and the clock-like regularity which everywhere prevails. From open admiration and wonder the feeling soon changes to awe as the visitor grasps the magnitude and precision of this great system, devised and maintained, it would appear, solely for the benefit of suffering humanity.

But the reader has already had glimpses of conditions in hospitals and sanitariums[1] that were anything but ideal, and so will be prepared to learn that in many even of our most famous institutions there is another and less attractive side to the picture. This we will now examine.

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[1] Although my references to private sanitariums have been far from complimentary, I have thought it best to devote this chapter exclusively to public institutions. For no matter how ill-managed a hospital may be, it is nevertheless a *hospital* (Latin, *hospes,* a guest), whereas a private establishment is first, last and always a commercial enterprise. In brief, public hospitals should be reformed and kept at a high standard; private health-shops, under whatever name, *abolished.* Says Dr. L. Emmett Holt in the paper already quoted from in Chapter I:—

> "A well-known and very successful gynecologist said to me once that he had reached the conclusion that no man could be strictly honest and conduct a private hospital. This statement, although perhaps an exaggeration, expresses an important truth. The temptation may be great. The enterprise has imposed heavy financial obligations. It has not proved the success the surgeon had anticipated. The year has been a poor one; rooms are vacant and expenses are going on. A well-to-do patient seeks his advice. An operation is not necessary, and, though at another time the surgeon would not himself have advised it, he finds it easy to do so now, and possibly justifies himself by the thought that many of his colleagues do the same. Such a step once taken, a similar decision is reached the second time with fewer misgivings, and soon the policy of doing operations with insufficient indications may become his established practice. If not an operative case, the patient may be induced to submit to prolonged but unnecessary and even useless treatment. There is subtle temptation here for every physician or surgeon whose eye is always on the almighty dollar; but it comes with increased force to one whose financial needs are great. His vision of right and wrong must be very clear and his ethical standards high not to be biased in such emergencies."

The visiting surgeons of hospitals are ordinarily men of experience and ability, a fact regarded by the prospective patient as of the utmost consideration. It also influences the philanthropist, who thinks that in contributing to the charity wards he is placing poor, helpless creatures in the hands of the most humane and skilful operators. How fortunate for the poor, and how gratifying to their sympathizers, that the humblest outcast may have as good surgical attendance as the millionaire! It almost savors of Utopia!

All of which is very well in theory, but hardly borne out in practice. For instance, I was informed by a nurse recently that a house surgeon in one of the largest New York hospitals had performed, during his first few weeks of service, no less than seventy-five major operations, and that the attending surgeons were in the habit of giving most of their work to this young man unless they got paid for it. So that any non-paying patient who enters this particular institution expecting to receive the services of one of the famous surgeons connected with it at least by name, will simply be turned over to an assistant who is allowed to operate pretty much as he likes. He may be a very fair surgeon by this time—he certainly ought to be after such experience—but he is not a master surgeon, and the patients are deceived.

If I were to go to the Post Graduate Hospital of New York, a poor man, and were placed in the surgical ward of Dr. Robert T. Morris with the understanding that he would operate on me, I should strenuously object to being turned over to an unknown house surgeon. I should want Doctor Morris to operate on me because I know that he has skill and sound surgical judgment, and is a conscientious, conservative surgeon, whose ability and knowledge are famous the world over. I only mention Doctor Morris by way of illustration, for I do not think that men like Doctor Morris, or Doctor Wyeth, or Dr. William Mayo would break a promise made to a patient, were he rich or poor.

This nurse, whose veracity is beyond question, assured me that she had seen a number of our great surgeons sterilize their hands, go to the operating table, make the first incision, and then turn the case over to the house surgeon, telling him to get busy and finish it up, as they had to hurry away.

From my experience as a medical student in Chicago and from visits to the leading hospitals in all parts of the country I am convinced that this abuse is common to all of our great cities, and, I presume, to those of Europe as well. Particularly, I believe, is this so in the medical wards, where treatment by proxy is often the rule rather than the exception. Sir William Wilkes, the famous English physician, remarked on his retirement from the consulting staff of a London hospital that he supposed he was a " consulting physician " because no one ever consulted him. " It might be well," remarks the London correspondent of the *Therapeutic Gazette*,[1] " if the exalted rank of consulting physician carried with it some opportunities for bestowing on the hospitals the often invaluable help of long years of large experience."

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[1] The *Therapeutic Gazette*, July, 1907.

It cannot be denied, of course, that charity patients are, as a rule, fortunate in having the surgical attendance of reputable house surgeons or sometimes even of internes, for these young men are graduates and are certainly possessed of some skill. Nevertheless our philanthropists have in many cases stipulated that certain endowments were given expressly to insure the best medical and surgical treatment that the hospital could provide for the poorest patient. In any case, it is inexcusable to deceive these patients and allow them to be operated on under false pretences.

There is no better way to judge a doctor's character than to study his respective methods of treatment in charity and pay cases. A modern hospital is supposed to provide charity patients with all the *essentials* in the matter of treatment that the case demands. Essentially, then, a pay patient gets no more than a charity patient. The presence or absence of many of the luxuries which pay patients are able to command is really not very important *per se*. The main thing is the treatment,—medical, dietetic, and hygienic,—and both classes of patients usually get this.

In certain places, however, we see lamentable exceptions to this rule. For instance, a well-known gynecologist of New York, who often performs the operation of hysterectomy, or complete removal of the uterus, makes his charity hospital cases sit up on the second day following the operation.

It is quite different with his pay patients. These he keeps quiet in bed for a much longer time. The operation is formidable, and the thought of permitting or requiring a poor woman to get up on the second day is sickening. The fact that the man treats the two classes of patients so differently is a sure indication that his rule for the charity patients was not made with any reference to their welfare. Why, then, does he do this? Probably to get rid of them quickly, as they have no money, and therefore are not of any further interest to him after the operation has been performed. Or perhaps the desire to be quickly rid of the poor patients emanates from the hospital authorities, and the doctor, for reasons of his own, acts in accord with their wishes.

A similar practice goes on in a certain maternity hospital. The chief obstetrician requires the inmates to get up on the second day after confinement, if they are charity patients, but in the case of pay patients he makes them remain in bed for several weeks.

Now every doctor, and nearly every layman, knows that when a woman gets up too soon after confinement she is liable to complications that may ruin her after life. And yet this famous specialist in obstetrics and gynecology gets his confinement patients up on the second day—that is, if they are charity cases. His reasons may be similar to those of his brother specialist above referred to, or again, perhaps he has a deeper plan. He is a gynecologist and desires future material; he knows that cases treated as he has treated his charity patients are liable to surgical complications. Having been to his hospital once they are liable to come again,—hence, whether or not he entertains such a diabolical motive, he is unquestionably providing ample clinical material for the future.

Of actual brutality toward the defenceless recipients of charity—often frail women or frightened children—I wish that I could remain silent. To picture a man of high attainments as essentially a savage is not only a reflection on the profession at large but upon modern civilization. Yet brutes there are,—alas, only too many of them!—among doctors and surgeons, and in the charity department of a hospital they find abundant outlet for their cruel or perverted instincts.

Of course, in the treatment of minor surgical conditions at free clinics and in the hospitals, and in many surgical dressings and manœuvres, it is often impossible to avoid giving more or less pain, even when the utmost gentleness is exercised. It is safe to say, however, that in most of these cases pain can be pretty nearly eliminated by the judicious employment of cocaine, eucaine, freezing mixtures, gas or chloroform. But to make use of these things means time and expense, and that is just where the trouble comes in. The surgeon is usually in a hurry; partly because there is a room full of other charity patients waiting; perhaps because he is anxious to get back to his own private office where each of his treatments means money in his pocket. As regards the institution itself, the superintendent may be unwilling to issue sufficient quantities of these pain-killing drugs. A spirit of economy is rampant, though too often only a cloak for wholesale "grafting."

All of us understand what pain is, and none of us, who have been so unfortunate as to break an arm or a leg, but can vividly recall the visit of the family doctor and the painful experience of having a broken limb examined and set. No matter how much nerve we possess we still remember with a shudder the intense agony accompanying the treatment of the most ordinary fracture, and we wonder if the pain might not have driven us insane had the doctor been unsympathetic or rough in his methods. Of course, nowadays, if we care to have the best surgical attendance either within or without a hospital,—and who does not?—an assistant can be called in to administer a little nitrous-oxide gas or chloroform while the bones are being put in shape again, and then we appreciate what a dollar is worth.

We may realize, therefore, with a shudder of horror, what it means to place a little child at the mercy of an unfeeling surgeon and then to withhold the trifling quantity of anæsthetic that would free it from all pain while its broken leg or shoulder is being set. The suffering, both physical and mental, that a sensitive child endures is excruciating to a degree, and the very thought of it should make our hearts ache for the unfortunate little ones whose parents are too poor to pay for the more humane treatment.

Disregard for the needless suffering of charity patients, especially children, cannot possibly be condoned or excused. In spite of the great and noble work done by the hospitals and free clinics, there is occasion for shame and indignation when we have to stand by and see helpless children with broken limbs being twisted and turned and pulled and jerked around with no one to raise a voice of protest and no law to invoke to mitigate their needless suffering.

I know of many city hospitals where this cruel practice still obtains of bone-setting without the aid of a little gas or chloroform to ease the sufferer, and the excuse in every case is the need of economy. Yet the material would cost but a few cents—probably less than the cigar that the operator lights when the clinic is over—and this paltry sum, and the callousness of the hospital authorities, are all that stand between the agonized patient and a quick, painless operation.

I once saw in a free clinic a surgeon, or rather a butcher, dissect a fatty tumor larger than a teacup out of a patient's back without giving him the benefit of any local or general anæsthesia. He explained that it "wouldn't hurt much, and anybody with a little nerve could stand it." The operation was only commenced, however, after the young man had been securely tied and plenty of assistants summoned to hold him down. The patient swore and carried on rather rudely, as he had a right to do under the circumstances, but the job was finished, and all the doctor had to say was "Why, man, you're a baby; you've got no nerve!"

Visiting a Chicago surgical clinic held in one of the college amphitheatres I saw a little girl, aged nine, brought into the clinic to have her tonsils and adenoids taken out. The mother was informed that "anæsthesia was unnecessary in simple cases of this kind."

"Now," continued the surgeon, "if you will hold the child I won't be a minute." The mother did her best to hold the terrorized girl, but it was no use, she simply couldn't. Then an assistant and nurse got hold of the child and held her while the brute put a mouth gag in her mouth to pry it open. This accomplished, he went after tonsil No. 1 and got it out, and then tonsil No. 2 was amputated, and afterwards the adenoids were gouged out. The operation completed, the little patient was released, and because she cried rather hysterically the surgeon deliberately pushed the bleeding child and her mother out into the hall with a farewell curse which was brutal in the extreme. Both were afterwards found on the college steps. The little thing's clothing was covered with blood and a kind-hearted student took her back into the building and let her wash up. The poor mother explained that she had been afraid to go home for fear her daughter would bleed to death.

This demonstration was so brutal, however, that the disgusted class petitioned the faculty to remove the surgeon, which promptly led to his resignation.

In the same clinic I saw another surgeon, who enjoyed a wonderful reputation for his nerve, perform a circumcision on a colored man without any anæsthesia. When asked why he did not use an anæsthetic his answer was: "Oh, ——! you don't want anæsthesia for such a small operation, and, besides, he hadn't a dollar to pay for it."

This surgeon greatly prided himself on his ability to jerk out ingrowing toe-nails rapidly, and to my knowledge he never used anæsthetics with any of his charity patients.

Another case of the ill-treatment of a child occurred at a clinic which a friend of mine attended. I give the particulars as he narrated them at the time.

A little girl, twelve years old, was brought to this clinic by her mother. They were poor people, but in manner and speech they showed that they had once been in better circumstances. Several months previously the child, while playing, had run a long thick splinter deeply into the calf of her right leg. Not being able to pay a doctor, the mother extracted as much of the splinter from the wound as she was able to, though she feared that she had not got it all out. The wound healed, but a tender spot remained. This gradually worked its way down the leg, past the ankle, and finally came to a standstill under the skin of the instep of the foot. It grew so painful that a shoe could not be worn, and at last the mother became so alarmed that she conquered her repugnance and took her daughter to the free clinic. Doctor F. was a big man with a ferocious expression on his face, and a harsh voice. When he glared at the little girl over his spectacles she trembled with terror and clung to her mother. Doctor F., however, made her climb on the table and began an examination of the foot. Of course, it must be understood that some pain is unavoidable in such examinations, even when the surgeon is gentle and considerate. But Doctor F. is not noted for gentleness or consideration, even with children, especially if they are charity patients. So he manipulated the swollen and tender instep in this way and that, and kneaded it vigorously with thumbs and knuckles. The child endured this part of the ordeal with more bravery than many a full-grown man would have done.

At last Doctor F. located a hard linear body beneath the swelling, and called for a knife. When the poor child heard this she turned white, and looked appealingly with her big brown eyes from the callous surgeon to the students who stood about the table, and in whose faces she read sympathy and pity. One of the students plucked up courage and suggested the employment of cocaine. "Too much trouble," growled the surgeon. "Anyway, what's the use—I don't need it." The student subsided into his proper place and was assigned, with two others, to hold the suffering little one on the table while the great man operated.

The vivisection began with a deep transverse incision across the instep and down almost to the bone. The child cried out and writhed in agony, but still she made a brave and pathetic effort to control herself. But when the doctor laid aside the sharp knife for a pair of dissecting forceps and began prodding between the exposed and quivering tendons in search of the foreign body, the little sufferer could bear the torture no longer. For the next five minutes or so her screams were nearly continuous. Several first-year students not yet hardened to such scenes, left the room. At last the search was successful, and the foreign body was caught in the jaws of the forceps and extracted. It proved to be a piece of wood about half an inch long and somewhat thicker than a match. The rest was comparatively humane—merely the insertion and tying of two stout stitches by means of a needle—dull, it is true, but plied by a gentle hand. The student who dressed the foot spoke soothingly to the little patient, and when her sobbing had about ceased, assisted her to the street.

But hospital abuses are not confined solely to the treatment of non-paying patients and I will now invite the reader to extend his sympathy to the paying patient as well. The latter, in fact, frequently undergoes hardships that could easily be avoided by a reform of existing conditions. I refer to the red tape and "ethical" bickerings incidental to his admission. The situation is well set forth by the editor of *American Medicine,*[1] who writes:—

> "The hospital problem is bound to call in the near future for serious attention on the part of thinking medical men. No one can deny that the development of medical eleemosynary institutions has been largely responsible for the progress of medical and surgical science. But coincidental with the growth of the hospital idea, grave dangers to the rank and file of the medical profession have appeared. In most communities wher-

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[1] *American Medicine,* September, 1908.

ever one finds a hospital, there also will one find a small clique of medical men enjoying especial advantages and privileges by virtue of their hospital connection. Their less fortunate and influential colleagues are denied these advantages, and are proportionately handicapped in the practice of their profession. Since to send patients to such institutions is tantamount to losing their patronage nine times out of every ten, the 'outside' practitioner naturally discourages hospital treatment except as a *dernier ressort*. . . . All these things tend to defer the well-recognized benefits to be derived from hospital regimen, and it is a notable fact that hospital cases are usually advanced—not infrequently too far advanced. Therefore if hospitals have not fulfilled their most complete function in any community the reason can usually be found in rules which confer special advantages on a few medical men and rigorously deny any privileges to those outside the 'charmed circle.'

"The ideal hospital system, and one that sooner or later must be adopted, is that which offers to every medical man the opportunity of placing his patients in any hospital he or they may elect, there to treat them with all the freedom that is his as a legally qualified practitioner of medicine. . . . Hospitals will then become in reality what they were originally intended to be, institutions solely for the use and welfare of the public, and not institutions for the promotion of private gain, professional or otherwise, as under present conditions is too often the case."

When professional negotiations have been brought to a successful issue, however, and the patient has been duly admitted and operated on, one would suppose that his trials are over, and that the skilful surgeon who has just dragged him from the jaws of death will now conscientiously strive to bring about his complete recovery.

But this, unfortunately, is by no means a certainty. Many surgeons regard a hospital as an operating institution, pure and simple, and consequently lose interest in their patients once they are operated on. Hence during the more or less protracted period of recovery the patient too often finds himself neglected, and is actually encouraged to leave before his condition at all warrants such a step. Waxing indignant upon this subject, Dr. Bayard Holmes[1] (of Chicago) exclaims:—

> "Modern aggressive surgery has made the hospital a hotel for the temporary care of the vivisected. All that the surgeon cares for is a room for his patient to occupy during the three or four weeks she is recovering from his incisions. She may then go home and get well or lead a life of invalidism, as it happens. To cure his patient and restore her to a life of usefulness and happiness is not the modern surgeon's conception of duty. He looks on the invalid as an encumbrance to his hospital, and all the essentials of recovery as unnecessary expense and space-consuming impediments."

There may be some exaggeration in this, as the editor of the *American Journal of Surgery*[2] vehemently asserts, but as such conditions undoubtedly *do* prevail and contribute not a little to the sum of human misery, I should not feel justified in omitting Doctor Holmes' indictment, even though, as this talented editor asserts, the statement "is very apt to be seized upon by enemies of the profession and triumphantly announced as another confession from our ranks." After all, worse things could happen than a thorough investigation of the abuses referred to or set forth in this chapter.

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[1] The *Journal of the American Medical Association,* March 28th, 1908.—"A Suggestive Plan for a Hospital of Five Hundred Beds."

[2] "A Surgeon's Opinion of Surgeons."—April, 1908.

When it comes to business methods, it is surely no secret that some of our largest hospitals are wofully mismanaged. “Graft” or incompetence, or both, are unearthed with such startling frequency that one wonders what would be the outcome of a thorough investigation, nation-wide in its scope, such as the Carnegie Foundation has made in the field of medical education. Some institutions would unquestionably issue with flying colors, but the majority, I fear, would come in for well-merited criticism.

In a certain metropolitan hospital, for instance, it was recently discovered that the orderlies, nurses and kitchen help were getting the cream off the milk, and that this had been going on for months. The poor, suffering little folks, whose very lives depended on this cream, had been fed on skim milk, which probably explained an abnormal increase in infant mortality in that particular institution. Of course, there was some brief unpleasantness, but as the press had not learned of the scandal, the hospital authorities were lenient with the culprits, and harmony and good-will were soon restored. Whether those sick babies are getting cream to-day, or have again been put on the skim-milk diet, I cannot say, and I very much doubt if the Superintendent could either.

In pleasing contrast to this deplorable laxity is the method pursued in a government institution. “Red tape” there may be in Uncle Sam’s hospitals, and in some cases antiquated methods, but “graft” is almost unknown.

While serving as interne at the U. S. Marine Hospital in Chicago, under Surgeon Henry W. Sawtelle (now retired), I had an opportunity of seeing this milk problem handled as it should be. Some of the patients had complained of getting poor milk, and within half an hour the most sweeping and systematic investigation was in progress. The head surgeon went straight to the kitchen and questioned the cook and his assistants and then, with commendable impartiality, interrogated every nurse and orderly in the place. The stewards and physicians were consulted as well; in short, every one in that hospital was invited to help solve the problem why the milk should be poor when the United States Government was paying for the best.

When the fact was established that the milk had not been tampered with in the institution, the proprietor of the dairy was promptly ordered to report at the hospital and explain why the milk he furnished to the Government under contract was not up to specifications. I shall never forget the appearance of that guilty milkman as he tremblingly admitted having watered the milk.

"My dear sir," said Doctor Sawtelle, "the United States Government pays you to deliver milk, not 'milk and.' Hereafter, if we decide that the milk is too rich, we can add our own Lake Michigan, and remember, sir, we are going to inspect every drop of milk that comes to this hospital hereafter. Any more complaints and you will hear from me in a way that will be very dear and disagreeable. That is all."

A systematic inspection was thereupon established, and daily reports on the milk and food in general were given to the surgeon in charge. During months of service in that hospital I never again heard a patient complain of poor milk.

I mentioned " red tape," but as a matter of fact a government hospital in charge of commissioned medical officers is superior, both in its methods and its discipline, to the average county or municipal institution. And the reason of this is not far to seek. There is an official head, and he is responsible to the government. On the other hand, the county or city hospital is run by a board of governors or managers, usually rich men who lack experience, and apparently care very little how things are managed. These boards generally put some incompetent man in charge and leave him pretty much to his own devices. He is often paid so small a salary that after he gets " on to the ropes " he will justify himself in making a " little on the side." The contracts for coal, food stuffs, medical supplies, etc., are made by him, and of course he knows upon which side his bread is buttered. "Graft" here and "graft" there keeps his mouth closed, and so the supplies may deteriorate until his management is an open scandal before he will consent to interfere.

Hospital " grafting " has become so universal that it is now almost considered legitimate. For, of course, the example of the " man higher up " is diligently copied by the rest. Thus the kitchen force are in the habit of helping themselves to tea, coffee, sugar and other groceries, which they carry off to their homes. The orderlies and nurses are more attracted to the medical stores, and thermometers, bandages, and minor operating instruments consequently disappear with wonderful regularity. The interne, when he has finished his apprenticeship, usually finds that he is well equipped to establish himself in practice. Silkworm gut, catgut, bandages, chloroform, ether, etc., are expensive items, and he argues that the hospital can well afford to help him out.

The physician in attendance, not to be left in the cold, usually appears at his clinics with an empty bag in which to carry off his share of loot. And so the game goes merrily on. A doctor of my acquaintance makes it a habit to go to the clinic three times a week for the sole purpose of " stocking up," as he calls it. His black surgical bag has six bottles in it, and these are filled thrice weekly with alcohol, ether, chloroform, lysol, green soap, peroxide and anything else that he especially needs. One day I ran upon him while he was filling up his bag and asked him what he was doing. He explained that as he gave his services free he thought it was only right to get all he could, so he was " stocking up," as was his habit after the clinic. His office was filled with his " legitimate graft," taken from the hospital clinic room, and he has told me many a time that he seldom has to buy any necessary office supplies.

The drug room in the average hospital, even where open looting does not prevail, is a great source of waste. Alcohol, bandages, gauze pads, medicines, etc., are handed out *ad libitum*, and there seems to be very little supervision when new supplies are being ordered. If the poor sufferers in the wards and at the clinics were the recipients of this lavishness, one would be less inclined to criticize, but here, as we have seen, is the very place in which a tardy economy is applied. Truly to him that hath shall be given and from him that hath not shall be taken even that which he hath—a right to!

It must be admitted that great injustice is often done to the attending physician in the matter of remuneration; nevertheless, since he accepts the conditions he should stick to his agreement or else resign. Furthermore, it is not the doctor who is most considerate and generous with his services who receives the most perquisites—on the contrary, it requires but little knowledge of human nature to see that the "graft" is usually in inverse ratio to the services performed.

Such stealing as I have here instanced would be next to impossible in a government hospital. There everything must be accounted for, and if there is an unusual outlay in any department the surgeon in charge will soon find it out. The difference between the two classes of institutions is that in one we have a system based on responsibility which time has proved to be good for all concerned, whereas in the other we have a system which by its irresponsibility invites and fosters "graft." Hence to destroy the "graft" we must alter the system.

Lack of intelligent coöperation among the various members of the staff is another cause for prevailing conditions and results in many deplorable blunders, some, of course, fatal. If the chief surgeon, the house surgeon, the internes and the nurses fail to work in harmony, even though all were actuated by the highest motives, the patient necessarily suffers. Space will not permit an enumeration of the various causes of discord, but in many cases the fault lies with those in charge. The head doctor, for instance, may be a conceited, pompous fellow whose chief concern is to impress his subordinates with his superior knowledge and skill. To such a man any observation or suggestion from others would be unwelcome and irritating. Consequently those serving under him learn to refrain from mentioning circumstances that have come to their notice in the condition of a patient which ought to be taken into account in the treatment. How horrible a blunder may result from such over-confidence we have already seen in a previous chapter, but no words of mine could depict the aggregate misery springing from this ignoble motive.

In speaking of the looting of expensive materials I have perhaps given the impression that the supplies purchased, whatever disposition is made of them, are the best procurable. This unfortunately is not the case. Whatever may be the quality of the items selected by the visiting physician and his friends, the materials reserved for the poor inmates are often of inferior quality, such as no reputable doctor or surgeon would use in private practice. In this connection let me quote again from the editorial columns of *American Medicine*[1] :—

> " In the selection of surgical supplies, it would seem above all things that quality should primarily be considered. Yet it is a fact too well known to innumerable surgeons that many a hospital is purchasing its supplies with a view only to cheapness. As a consequence, surgeons in such institutions are too often forced to use suture material, dressings, anæsthetics and a hundred and one other essentials to surgical technique, that they would never think of employing in their private practice, or in the treatment of members of their own families. The excuse of *economic* necessity is always made by hospital boards when criticism is directed against inferior surgical supplies, but the fact is apparently overlooked that the exercise of this particular form of economy is simply meeting one responsibility by creating a greater. A treatise might well be written on the criminal reprehensibility of using inferior surgical dressings or sutures, and it is an outrage for any hospital to ask the members of its surgical staff to place themselves in a position so open to censure and possible injury.

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[1] *American Medicine,* October, 1908.

This would be bad enough in itself, but the particular abuse under discussion comprehends much more vital dangers to helpless patients, who have no voice in the matter. Who can say to what extent unnecessary suffering, disappointment at faulty results, and even deaths following operations, have been due to the use of cheap dressings, sutures or other hospital supplies?"

If a treatise could be written on the above-mentioned abuse, what a library might be written on the haphazard methods of prescribing and filling prescriptions that obtain more or less in every hospital in the land! With all the shortcomings of hospital surgery, no one can deny that it has laid the foundations of progressive modern surgery the world over. In *materia medica*, on the other hand, the hospitals have lagged so far behind that it is a question if the term "modern" can be applied to anything relating to the pharmaceutical department.

"In the one hundred and fifty years of the practice of pharmacy in American hospitals," writes M. I. Wilbert, Ph.M., in the *Journal of the American Medical Association*,[1] "we can only point to one hospital pharmacist who idealized his position and was able to accomplish something that we of to-day may rightfully point to with pride."[2]

After a careful survey of this important but neglected field, Mr. Wilbert lays much of the blame upon what I may best term a *mechanical blight*, which makes the average medical department a mere machine for drug giving. This also is the opinion of the *Journal of the A. M. A.* itself, which came out shortly before Mr. Wilbert's paper with an editorial entitled "Mechanical Prescribing in Hospitals and Dispensaries."[1] The editor says:—

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[1] A paper read before the American Medical Association (Section on Pharmacology and Therapeutics) held at Atlantic City, June, 1907. Published in the *Journal of the A. M. A.*, November 16, 1907.

[2] The late Charles Rice, who was connected with the drug department of Bellevue Hospital, New York, for forty years.

"The best-managed hospitals have their standard tonics made up by the gallon, if not by the barrel, and prescribing in dispensaries is commonly slavishly confined to a formula book. The student soon learns that 'Formula 38' is good for dyspepsia, and that 'A. B. and S.' pills are the remedy for constipation. It is unfortunately true that the prevailing tendency to rely on nostrums and specifics has its origin to a large extent in the use of formularies and ready-made mixtures in clinics, dispensaries and hospitals connected with medical schools. That some of the best men in the profession exhibit this tendency is not surprising when we know that a certain college, second to none in its advocacy of high ideals in medical education, still uses in its dispensary work a formulary book that has undergone little change in twenty years and which contains some beautiful examples of polypharmacy. While such a reliance on ready-made formulas may be a necessity of the busy doctor, it is certainly out of place in the teaching of students, where the underlying principles should always be kept in view and their intelligent application in detail carefully taught. The student, taught by the powerful example of great clinicians whom he sees daily using ready-made formulas, is in great danger of letting his lessons in pharmacology lapse into innocuous desuetude and of going into practice ready to exchange the ready-made formulas of the dispensary or the clinic for the ever ready specific of the proprietary medicine man."

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[1] The *Journal of the A. M. A.,* August 17, 1907. Dr. Oliver T. Osborne (of New Haven, Connecticut) in the discussion of Mr. Wilbert's paper, above referred to, agreed thoroughly with the speaker and added some startling facts of his own. His statement, he explained, applied not only to the New Haven Hospital, but to students in all sorts of hospitals out west, south, east and north. Everywhere he had come in contact with men who have been in hospitals and show a woful lack of knowledge of prescription writing. Junior students, he said, write better prescriptions than the seniors, and the seniors better than hospital graduates. There is a progressive deterioration as the student remains in the hospital.

The relation of the hospital to scientific medicine and to the work of the medical school has already been considered, though so inadequately that I have included in the Appendix a vigorous " Plea for Hospital Reorganization," by Dr. Graham Lusk,[1] in which this phase of the question receives the emphasis it deserves. There are, moreover, many other abuses and shortcomings that I have not even mentioned, particularly in the conduct of the medical wards of prisons, charitable homes and asylums; but these institutions, I am glad to see, are receiving considerable publicity in a number of the popular magazines. Inadequate and crowded wards, insufficient ventilation, cruel and vicious attendants recruited from reformatories that do not reform, and often direct from the slums, the lack of entertainment for convalescents, the stupid, maddening routine that so largely prevails, and, in children's hospitals or homes, that lack of personal care or affection for the babies which Doctor Ruhrah (of Baltimore) pleads for under the term " mothering "—these, among other evils, are the cause of the high death rate in our charitable institutions and of the

[1] Appendix K.

wretched physique of so many who survive. Which simply means that Society, while on the one hand fighting squalor, disease and crime, is counteracting the good results so attained by contributing a host of unfortunates to people the slums, and so supplies, deliberately and with apparent indifference, what may be regarded as one of the chief factors of our moral and physical deterioration.

Hence, like every other evil in our eleemosynary institutions, it is not only the helpless victims who suffer, but eventually the public at large. Injustice, incompetence, cruelty, dishonesty, selfishness are diseases that cannot be restricted to the hospital ward or the clinic. They may be suppressed for a time and their existence denied, but the danger is none the less real. If we deny mercy to those whom misfortune has placed in our charge, prolonging their sufferings and endangering their lives, we do but call down a worse affliction upon ourselves. The abuses that exist in our hospitals are a festering sore, not only upon the medical profession, but upon the whole community, and only the most drastic measures will prevent its malignant growth until the very soul of the nation is imperilled.

# CHAPTER XIV

## HOW AND WHEN SHALL THE REFORM COME ?

Had the preceding chapters of this book dealt exclusively with the abuses that have crept into the practice of medicine, had no attempt been made to ascertain the causes of the evils specified, and no suggestions been offered for their correction or removal, I should feel that my work had been essentially destructive, and that a final chapter on constructive lines could rightly be regarded as a mere after-thought, and so would but serve to emphasize the prevailing iconoclasm.

Such, however, is far from being the case. Not a page that I have written can justly be interpreted as antagonistic either to the true spirit of medicine or to that honorable minority to whom I have repeatedly referred, who have dedicated their time and talents to the service of suffering humanity. The real enemies of the profession are the "grafters," quacks and bunglers whom I have denounced, and it surely requires no keen perception to see that what is destructive to this parasitic element should prove correspondingly helpful to the cause of true progress, those ideal conditions of which our great men have dreamed and prophesied, and for which so many valiant souls have hoped and striven and died.

Let us, then, in this concluding chapter, attempt a brief *résumé* of the abuses I have outlined, and consider what immediate steps can be taken to purify and elevate the profession. There may be much disagreement both among my colleagues and the laity as to the wisdom of some particular method or enactment, but so long as I have secured *a unanimous demand for reform*, I can surely afford to submit to the most drastic criticism of the means and measures suggested.

Physicians and surgeons have become too autocratic, they are entirely too immune from criticism, their blunders and shortcomings receive altogether too little publicity; their guild savors overmuch of medievalism. Unquestionably the methods of the practising majority are deplorable, and the abuses, instead of being exceptional, are the rule.

It is, of course, impossible in a book of this size to do more than touch upon certain topics, and it is also impossible to point out all of the common, flagrant mistakes. Volumes could have been written from the data on hand showing the widespread demoralization, " grafting " and incompetence, and the unprogressive methods and ideals.

Medical "graft" will inevitably bring its own penalty. A little publicity, such as the fee-splitters of Chicago received a few years ago, will accomplish much; but wide publicity—as extensive as the evil itself—is the only permanent safeguard. While the public are often helpless in judging of a doctor's efficiency, they are showing a remarkably clear understanding regarding the proper prices for medical services, and a physician is no longer able to hoodwink his clientèle into thinking they should pay excessively. The attempt is constantly made, however. Obstetrical cases, for instance, vary in charges to an outrageous degree. I have a friend who attended a poor woman in her confinement and charged her eight dollars; the week following he attended another woman in one of the large city hotels and asked a thousand! He got the eight dollars on the instalment plan, but only four hundred of the thousand was paid, because the family had paid the same amount to a Chicago specialist two years previously. The physician was perfectly well satisfied with the four hundred, but the letter accompanying the remittance, calling him a "grafter," irritated his sub-conscious self.

It must be admitted that this matter of fees has long been a vexing question both here and abroad; but a public opinion has slowly been forming which demands that the physician, like any other professional man, charge solely for the services that he has rendered. The moment he is allowed to levy upon wealth or to take advantage of another's misfortune, he starts upon a career of commercialism, the end whereof has been clearly set forth.

The stock-company medical schools, which are the hotbeds of commercialism as well as incompetence, should be ruthlessly abolished. This is a matter for legislation. The charters of such schools should be instantly revoked, for not only do they teach poorly and insufficiently and graduate a host who are intellectually unfit for the profession, but they unquestionably, by example alone if by nothing else, inculcate the very essence of the "graft" spirit. Says Doctor Oviatt in the paper from which I have quoted in the first chapter:—

> " Another source of the graft evil is the existence of low grade, irregular and stock-company medical schools. In many of these schools the entrance requirements are not in evidence, outside of their catalogues. With no standard of character or ethics, these schools turn out men who have gained the little learning they possess in the very atmosphere of graft."

The paying of secret commissions or fee-splitting is also to be condemned, since such methods invariably lead to deception and fraud. Even if downright fraud were absent, such practices are pure commercialism, and are quite incompatible with any proper code of professional conduct. This evil is already being denounced and combatted by all reputable medical societies.

The code of ethics, as I think has been sufficiently shown, must be radically changed. The present regulations are both degrading and dangerous, and here, I fear, legislative enactments of a very decided character are needed. The physician who prostitutes his professional trust to protect or shield a brother practitioner should unquestionably be punished. Humanitarianism must take precedence over criminal clannishness. A system of common-sense laws must replace the existing system of common senselessness.

Education at the cost of human life must cease; for though the beginner must learn, and perfection comes only with practice, it is simply criminal and must be made so, to regard and treat a patient—whether he pays or does not pay—as a mere subject for experiment. The whole system of medical training requires revision and reorganization, commencing with the preliminary education which is so important, and, too often, so conspicuously inadequate. A common-school education is not sufficient preparation in any other of the higher professions, nor is it in medicine in the rest of the civilized world; yet the requirements in this country are at present so lax that the unfit and mentally untrained are freely allowed to enter our medical colleges.

This is a deplorable condition, and the sooner it is remedied the better. Years of fundamental work ought to have been accomplished before a student should become eligible to enter a medical school. It might be advisable to suggest that the candidates for matriculation should have a university degree. At any rate a thorough preliminary and advanced education is the only guarantee that a student is mentally fit to undertake the highly technical course that lies ahead.

A standardization of all medical schools would be beneficial. Dr. Isaac C. Gable (of New York) speaking at the Annual Meeting of the Medical Society of the State of Pennsylvania, September 23, 1907, urged " uniformity of state medical legislation," and recommended that " a fair and equitable bill, founded on uniform standards, be formulated and introduced in the legislature at its next session for the better protection of the citizens of the state. With enlarged powers through a compact medical organization will follow greatly increased possibilities for the accomplishment of good to the profession and to the state." Doctor Gable also emphasized " the evil of low standards in some of the medical colleges," and advocated " a higher and broader standardization in preliminary and medical requirements." I suppose I could quote hundreds of prominent men to the same effect.[1]

There are certainly far too many medical colleges turning out unfit material and unless the standard is uniformly raised, little can be hoped for. It would be necessary to adopt radical measures to accomplish much, and it might first be necessary to revoke the charters of the institutions unable to comply with more stringent laws. The standard of efficiency in the larger and more capable schools can be improved by lengthening the time of study to at least five years of ten months each.

The rapid advances in the science of chemistry, biology, bacteriology, hygiene, the many branches of surgery, and particularly, perhaps, in the newer science of preventive medicine, demand the severest mental application even of those whose preliminary training has been most thorough. Granted that the present course is altogether too broad and haphazard, and that modifications aiming at a more specialized training are imperative if the graduate of the future would preserve his sanity, it is nevertheless inconceivable that the student of modern medicine can master the work demanded of him in four years. The American graduate, in nine cases out of ten, possesses the barest smattering of general knowledge, and with such training is turned loose on an unsuspecting public to begin his life's work. Every young doctor, so equipped, has invariably had to pass through a year or more of the greatest humiliation and distress before acquiring a reasonable proficiency in his art. Dr. John A. Wyeth, speaking of this bitter period[1] in the lives of most young practitioners, gives the following graphic picture of his own experience:—

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[1] For the recommendations of President Henry S. Pritchett of the Carnegie Foundation, see Appendix A.

"I graduated in the spring of 1869, and I can never forget the sinking feeling that came over me when I realized how incompetent I was to undertake the care of those in the distress of sickness or accident. A week later, after arriving in my native village in Alabama, I rented a small office and attached my sign to the front door. Within two months, the tacks were withdrawn by the hand which had placed them there and the sign was stowed away in the bottom of my trunk. Two months of hopeless struggle with a Presbyterian conscience had convinced me that I was not fit to practise medicine, and that nothing was left for me but to go out into the world of business to earn money enough to complete my education. I felt the absolute need of clinical experience; and a conviction, which then forced itself upon my mind, that no graduate in medicine was competent to practise until he had had, in addition to his theoretical, a clinical and laboratory training, was the controlling idea in my mind when, in later years, the opportunity offered, and it fell to my good fortune to establish in this city the New York Polyclinic Medical School and Hospital."

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[1] Proceedings of the Nineteenth Annual Meeting of the Association of American Medical Colleges.

But the standard of our schools does not depend solely upon the character and acquirements of the students admitted. The teachers of these young men are too often ill-equipped themselves, and too poor or busy to give the time necessary to produce good results. The teaching staff, therefore, should be improved by the weeding out of all incompetents, and by paying adequate salaries to those who are well-qualified and can give the best of their time and thought to this supremely important work.

Dr. Graham Lusk, an indefatigable pioneer in this field, in his "plea for the development of leaders," urges that New York City should inaugurate a new era of efficiency by raising a $500,000 fund.

"Pay the professor of medicine," suggests Doctor Lusk, "half the income, or $10,000 a year, in return for which he shall spend half his day from 9 in the morning to 1 o'clock instructing students, making rounds in the hospital and supervising research work. He should have under him two assistants at $2,500 per annum, who should be permanent resident internes of the hospital and men who can grow to be professors of medicine. The $5,000 income remaining should be used for the expenses of research at the discretion of the professor. Some time, some day, some man who has the power to raise the money and the intelligence to use it rightly will be able to confer on this community the untold blessings which would follow the establishment of the chair of medicine for the training of physicians in an atmosphere of developing research."

After a man has received his college education, his real work of fitting himself for his important duties is only learned in the hospital. A graduate should have two years of hospital training, at least, before attempting to practise. The theoretical training of college is of little importance as compared with the practical work in a hospital under the guidance and tutorship of able men. Hospital training and teaching are of paramount importance, and until a man has had such experience he is wofully lacking as a practitioner. I think our American medical educators recognize the importance of hospital training as the most necessary part of a medical student's life.

In this connection let me quote from an admirable paper by Dr. Joseph Price[1] (of Philadelphia) in which the need of more widespread hospital training and of the consequent enlargement of hospital facilities is eloquently set forth:—

"There is a tendency at present throughout this country to build more hospitals, and I predict that where we have four or more good physicians in towns of 2,000 or more inhabitants, we are going to have a hospital and ought to have one. The material in these small cities, thickly settled, in manufacturing communities, is very abundant, and it is thrice important that we should have, at these points, well-trained men, disciplined men, who have served an apprenticeship in the educational centres, and who can do good surgical work. At present, much of the work done in a surgical way in these places is unfortunate. The mortality in the country from operations done by inexperienced men, without judgment, is great. There is but one way to correct it, and that is to compel these men to serve an apprenticeship in the educational centres. You have here in Chicago some of the most important and brilliant surgeons in the world; they are doing advanced scientific work. They are doing ideal work, but they are not doing the teaching they should. They should be paid salaries and compelled to teach. The residents in hospitals should be doubled and quadrupled, and every hospital in the land should be made a school. Public charities should be used wisely and mainly for educational purposes.

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[1] "The Importance of Specialties in Educational Centres." Read before the Chicago Medical Society, November 14, 1906.

"Tait distributed all over the world good operators simply by giving them object lessons. He demonstrated beautifully that if he could make simple object lessons he could make better operators by giving them an apprenticeship. I was one of his object-lesson pupils, as well as many others, and all of us, I think, have demonstrated the value of this by putting our pupils under us to work, making them serve apprenticeships and thus making them better operators than Mr. Tait made. The advanced thinkers and leaders in the profession—men like Mayo, Oschner, Deaver and Murphy—are not apprenticing young men as they should. While they are doing the advanced thinking, teaching and operating theoretically, they are not making men do the practical work they should do.

"I know from experience and observation, that the great teachers of this country are wasting material and are not doing the teaching and imparting the knowledge that they should. We are going to have hospitals at every cross-road where there are 2,000 or more inhabitants; we are going to have a polyclinic. The polyclinics of New York and Chicago will cease to exist except for those cities. At the cross-roads they are going to have their own polyclinics, so that it is important that we should educate and send a better class of men to the villages and to the cross-roads, men who have served an apprenticeship. I have sent them to such places in good numbers. I have sent a hundred men to their different homes who have written me a hundred letters telling me that the first one hundred patients upon whom they operated recovered. One hundred men, one hundred primary operations, and one hundred recoveries. Think of it!"

Medical schools should pay more attention to Public Health matters and sanitation. A slight knowledge of bacteriology or hygiene is, at the present day, insufficient. The growing problems of modern sanitation and public health involve a complete investigation of sociological and political conditions. It is a lamentable fact that our colleges have not taken these sciences more seriously. Great Britain and other countries are progressive in this respect, inasmuch as the subjects are taught minutely and methodically, special degrees being conferred upon those who show proficiency.

Commenting upon America's backwardness in this field, the editor of the *New York State Medical Journal* (March, 1908) says:—

"One of the great needs of our system of medical education is to train men to meet these new conditions. No college in our country has a course in hygiene and sanitation worthy of the name. Doctors are to be trained to fill the important positions, arising on every hand, in sanitation—municipal, state and national. Preventive medicine is the thing. The need of specially equipped men is becoming urgent. The first school in this country to train men as sanitarians will mark an epoch."

Let me quote also the opinion of Dr. Charles A. L. Reed[1] (of Cincinnati) who is one of the most earnest advocates of an active, national department of health:—

"No governmental agency is entrusted with the sanitation of interstate streams and the consequent protection of the people from typhoid due to these media of communication. There are no national laboratories for the solution of the yet hidden mysteries of contagion and infection. Other specific activities, such, for instance, as a campaign against disease-carrying insects, are not provided for, while the scattered agencies that we do possess are given such an unfortunate status in our scheme of government as to compromise their educational value and practically to deprive them of moral force."

Our hospitals, with very few exceptions, are in a lamentable condition. Here and there, good work is being done; but it is in striking contrast with the general inefficiency, incompetence and carelessness.

Recently I had an opportunity of visiting the Mayos of Rochester, Minnesota, and while there only a short time I was impressed with the methods employed by these great surgeons. A patient entering St. Mary's

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[1] "A National Department of Public Health." A paper read before the New York Academy of Medicine, October 29, 1908, and published in the *Journal of the American Medical Association,* November 28, 1908.

Hospital has every possible chance of recovering, for the methods in vogue at that institution are superior to any I have seen elsewhere. In the first place a competent corps of well-trained physicians is employed, each a specialist in his line, to do certain work. Before a patient is subjected to surgery, or any form of treatment, he is thoroughly examined by different medical and scientific men, to determine, if possible, his exact condition and the course to pursue. It matters not who you are, pauper or millionaire, the treatment accorded is just the same and the methods used are beyond criticism. A thorough examination is made, and a systematic history of each individual case is taken. The evidence is gone over by the individual experts in detail, and in due time, if necessary, the surgeons are consulted. Rarely do we find mistaken diagnoses in this hospital, and never do we find gross surgical blunders. I cannot say enough in praise of this remarkable institution. This Mayo system, as it may be termed, is ideal in every respect.[1]

There should be established in every public hospital, both in the hospital proper and the outdoor department, or clinic, a chair of physical diagnosis. The method of referring sick people to a clerk to be directed by him to some physician, is objectionable. Patients should be sent to the diagnosis department first, and after due time transferred to the proper department to receive treatment. To-day patients are in the habit of diagnosing their own ailments and going, as they see fit, to physician, or surgeon, or whomsoever they think they should see. Physical diagnosis is passed over too lightly in all hospitals. The most important part of the whole work is being done, unfortunately, in a more or less routine fashion, and this science has not had its proper share of attention. Unless the examiner has a clear, concise idea of physical diagnosis, he is unable to give proper relief, and may do much more harm than good.

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[1] **In Appendix C will be found another report of St. Mary's Hospital and the work of the Mayo Brothers, for I feel that this remarkable institution and system cannot be too widely studied.**

Each and every hospital should throw its public wards open to instructors, and should permit students, during college years, to study clinically the material on hand, in classes. While this is done in some of the large hospitals, the small ones where such practice is not in vogue are just as important, from the student's standpoint, and can be of great service and value in training our young men. Thus can Doctor Price's dream become a happy reality.

Before dismissing this subject I would urge that the burden of efficient hospital service be no longer borne entirely by philanthropists and self-sacrificing doctors, and that well-to-do patients who have heretofore, in surprisingly increasing numbers, taken advantage of the free dispensary, should not be allowed gratuitous treatment.

Another important phase of the situation is the personally conducted hospital, run for business purposes only. These establishments, known as "private hospitals," should be subjected to strict supervision, if not abolished. Such institutions tend to increase the abortion evil, inasmuch as secrecy can be maintained. They also foster incompetence and serve as a means for advertising medical and surgical practitioners whose skill, unfortunately, is invariably below the average. The staff of nurses, as a rule, is utterly unfit to care for the sick; the equipment is poor, and the air of commercialism which surrounds such hospitals is too suggestive of charlatanry.

I shall now briefly state what, in my opinion, should be done to organize a system which will prove most effective and valuable for the public safety and welfare.

Legislation ought to be enacted to modify the scope of the physician and especially to define the scope of the surgeon. The physician should have no more right to perform general surgery (except in an emergency) than a dentist has to-day.

Medicine and surgery would thus offer two distinct careers, as they do in England and nearly every other civilized country, with pediatrics, obstetrics and various specialties coming under the former division, and surgery subdivided into that of the eye, ear, nose, throat, the brain, heart, lungs and vessels. There would also be general abdominal surgery, orthopædic surgery, and gynecology, and, of course, pediatric surgery, obstetrical surgery, etc.

In contrast to our present haphazard, irresponsible system of personal election, practitioners should then be obliged to take thorough special courses under well-qualified instructors in these various specialties, and should be prohibited by law from practising until they have had sufficient experience in hospital and laboratory work and have demonstrated that they are really well qualified.

I am aware that the question is a much debated one, yet I should like to go on record as favoring the establishment of a National Bureau of Health, having under its supervision each of the State Health authorities. The

State Health Boards should have under their guidance, supervision and jurisdiction the numerous City Health Boards of their respective states.

The National Bureau of Health would fulfil such duties and exercise such powers as the following:—

Jurisdiction over all medical education.

Regulation of medical requirements.

Examination of all graduates.

The right to issue medical or surgical licenses to those who qualify; such licenses to be acceptable in all parts of the United States and its possessions.

The power to revoke any license at any time for just cause; to formulate authoritative regulations within certain clear limits; to combine under one head the U. S. Army and Navy and Public Health Marine Hospital Service, and to coöperate generally with the state authorities in all matters pertaining to medical education, public health, hygiene and quarantine.

The State and City Health Bureaus would have their respective duties as follows:—

Jurisdiction over all health matters of the state and city; local quarantine, matters pertaining to births and deaths, experimental research work, state, city and private hospitals, and local jurisdiction over physicians' and surgeons' work.

The National Health Bureau should have a check upon the work of the individual practitioner just as the local Health Bureau has, in a measure, a record of each individual contagious disease.

It is the custom in New York City to report all contagious diseases to the Board of Health. The Health authorities have a system whereby these contagious diseases are under a certain supervision until disinfection and disposition are complete. This system, in a modified form, could be organized so as to keep the authorities in touch with the surgical work of a community. Let Doctor A. or B. report by postal card or letter to the authorities that he performed a "Cæsarian section," or "laparotomy," or "ependicetomy." He should also be compelled to report the final disposition of the case, "Improved," "Cured," "Died." If death occurred, the cause of death.

The superintendents of all hospitals should likewise be compelled to report all operations performed at their respective institutions, and by whom, with the final disposition.

It is impossible, of course, to do more here than to sketch the barest outline of such a system, yet I am convinced that some form of statistical record will offer the only solution to many of the gravest problems presented in this volume. I must leave the subject to others to elaborate or condemn, however, and hasten through my brief programme of reform.

The field of surgery is vast and its intricacies are so manifold it seems only reasonable to suggest that post-graduate work should be taken up, and continued, at certain periods, throughout a physician's professional career.

Our post-graduate courses should consist of at least twelve months each, and should be practical rather than didactic. No practitioner should be permitted to take post-graduate courses until he has given proof by examination that he understands the principles of the subject he is about to study. His post-graduate work would then be worth something to him and would mean much to the public. His time would not be consumed in learning fundamentals which he should have known before attempting further study.

The future of surgery depends entirely upon the men who are to do it. It is the grandest and most exacting science of the age: a science in every detail and one in which triflers have no field. Surgery should only be performed by scientific, conscientious operators whose knowledge is beyond criticism, and whose ability as physicians and diagnosticians is well recognized.

But surgery is an art, as well as a science, and many who have mastered the intricacies of the human anatomy fail to develop that skill and technique which is absolutely essential to success. Hence the rank and file should no longer be allowed to operate at their pleasure. Inexperienced physicians should have no more license to prove their incompetence at the expense of the public than a bridge-builder or a druggist or a marine engineer. And especially will this be true in the near future, judging by the astonishing advances that are being made in every branch of operative surgery.

References have already been made in Chapter X to the pioneer propaganda in this country of Doctor Moore and to Doctor Rigby's daring proposal in England to establish a Surgical Court of Enquiry. Doctor Rigby's original paper in the *Independent Review* is reproduced practically in its entirety in Appendix L, yet I feel that it is but right to emphasize one paragraph in this connection. Concluding his appeal for legislation or other responsible control, he writes:—

> "Sufficient has now been said to answer my purpose; *i.e.*, to found a basis on which to establish my thesis that the present position of operating surgery has founded what is in fact a new tribunal, and one, moreover, of

great and far-reaching power with very little, if any, responsibility; and that in the interests of the people at large it is quite time this far-reaching power and lack of responsibility should be seriously inquired into, and that if it is found necessary its powers should be limited and its responsibility vastly increased by bringing each individual case operated upon, at any rate where a fatal termination ensues, under the notice and investigation of an authorized court of enquiry; either a new court of enquiry to be established for the purpose or some modification of the present Coroner's Court. In all other cases of death by violence or misadventure there is an enquiry made to determine if anybody be at fault and there is no reason why in this particular instance such an enquiry should be evaded. As before stated, if a merchant captain or a naval captain lose his ship or have it seriously damaged either with or without loss of life, or if a military officer lose a position, stores or men, an enquiry or court-martial is at once instituted and the officer in charge has to clear himself of incompetence, ignorance or want of due care in the discharge of his duties, and there is invariably an inquest on a person who dies under chloroform or any other anæsthetic. If so, there can be no reason why the operating surgeon in case of dire failure and loss of human life should not also be called upon to vindicate his conduct and capacity. If he were thus liable to be called upon he would be stimulated by a grave sense of responsibility not to enter upon or undertake any such operation in a flippant, uncertain manner, knowing that if he did so he would be required to furnish unimpeachable and incontrovertible reasons for having so undertaken it, and subjected his patients to perils of such consideration and moment as to involve the possible loss of their life."

Doctor Rigby's opponents in Great Britain vehemently contend that such courts of enquiry, whether by coroners or other persons, into cases of death after operation would hinder the advance of surgery. No argument need be brought forth to invalidate such a contention.

The amateur anæsthetist should be considered and special attention be given immediately to anæsthesia. This important work should be set aside as an absolutely distinct course and profession, the same as nursing. The profession at large should understand it, of course, but a separate chair of anæsthetics should be established in every college and well-trained men and women only allowed to administer it, after thorough preparation. There have been altogether too many ghastly fatalities, as I think has been amply proved, chargeable solely to our failure to regulate this highly responsible branch of medicine. Moreover, even where the anæsthetist has the proper training, he is usually an ambitious embryo surgeon whose attention is too easily distracted from the patient during the operation. If it is not thought best to train men and women specially for this work, I would earnestly recommend that the anæsthetist be shielded from view of the operator when practicable. Only the experienced surgeon can possibly appreciate the importance of having the anæsthetist pay strict attention to narcosis.

I am pleased to see in an English letter to the *Journal of the American Medical Association*[1] that the question of regulating the administration of anæsthesia by law in England is receiving widespread attention both within and without the profession. The letter says in part:—

"In a previous letter an account was given of the report of a committee appointed by the government to inquire into coroner's inquests. This committee has now issued a further report on deaths under anæsthesia. Leading anæsthetists, such as Dr. Hewitt, Dr. Buxton and Dr. Silk; eminent surgeons, such as Sir Victor Horsley, Mr. Pepper and Mr. Clinton Dent; physiologists, such as Sir Lauder Brunton and Dr. Waller; and leading dentists were examined. The perils of anæsthesia have attracted attention because of the great increase in the number of deaths under it in recent years. In 1866 the number of deaths registered as occurring in this manner was 5; in 1905 it was 155; in 1908, 235. But no absolute deductions can be drawn from these figures. As the law now stands, it is not compulsory to report a death under anæsthesia administered for a surgical purpose; all that is necessary is to assign some cause for death. A distinction has to be drawn between death from an anæsthetic and death under an anæsthetic. Under anæsthesia a person may die from the action of the anæsthetic, from surgical shock, or from hemorrhage, or from a combination of these or other causes, such as asphyxia from the tongue slipping back, or regurgitation of food. Without investigation it is impossible to say how far the anæsthetic is the cause of death. The number of operations has increased much in recent years and no statistics exist to show their relation to the number of deaths under anæsthesia. Still, when all sources of error are allowed for, there appears to be an increasing number of deaths under anæsthetics, and some of them are due to preventable causes. The committee thinks that every death under anæthesia should be reported to the coroner, who should exercise his discretion as to whether an inquest is necessary or not. As the law now stands, the administration of anæsthetics is under no regulation. Apart from criminal intent, a bonesetter, a "beauty doctor," or a quack of any kind is as much at liberty to administer an anæsthetic as a physician. Their only disadvantage is that if an accident occurs, the fact that they are not qualified is material evidence on the question of negligence. The committee thinks that this is a serious menace to the public, and that the administration of anæsthetics should be regulated by law. It is urged that it should be made a criminal offence for any unqualified person, who is not acting under the personal supervision of a qualified physician, to administer a general anæsthetic."

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[1] April 30, 1910.

A word regarding specialists. They are necessary—and every encouragement should be given the earnest worker.

Specialism has its place both in medicine and surgery, but to prostitute specialism as is now being done is absurd and lamentable. Specialists are not born, they are made. The attributes of specialism are insight, knowledge and experience, and their application to the science of practice is impossible without thorough comprehension and mastery. A reputation based merely upon the good will of the laity, has little value: it is the recognition of the profession which counts.

The registration of births and deaths demands effective legislation. Very little attention is apparently paid to this subject. Death, unfortunately, is held too cheaply, and births are regarded as commonplace, everyday occurrences of little importance. A more thorough and detailed description of births and deaths should be recorded. The following editorial from the *Medical News*[1] furnishes food for serious reflection:—

"Under the facetious but pertinent heading 'Glass Houses,' Dr. Cressy L. Wilbur, chief statistician of the

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[1] "The Lack of Vital Statistics," August 1, 1908.

Bureau of the Census, comments [1] on the frequent publication of the item about vital statistics in Turkey. To the question 'What is the death rate in your country?' the Turk is made to answer, 'It is the will of Allah that all should die. Some die young and some die old.' To the question, 'What is the annual number of births?' the Turk replies, 'God alone can say—I do not know and hesitate to enquire.' Dr. Wilbur very frankly calls attention to the fact that the American can give answers that are but little, if any, more satisfactory than those given by the Turk. As to the death rate in the United States, the government has been endeavoring to find this out since 1850. The registration of deaths is dependent on the enactment and enforcement of state laws or city ordinances and only fifteen of the forty-six states have been accepted by the Bureau of the Census as having sufficiently complete registration of deaths as to be dependable. As to the births, the American does not know the exact number of births each year for his country as a whole, nor for a single state, nor even for a single city. He also 'hesitates to enquire,' and has been hesitating for over half a century to take this matter up in a business-like and effective way. That one of the most enlightened countries on earth should even be comparable with the 'unspeakable Turk' in the matter of vital statistics is, in itself, intolerable. There are signs, however, that this bad record is to be bettered, and it is well worth the attention of all who can influence legislation on the subject."

But more important than any mere record of births and deaths, is the general record of medical incompetence and irresponsibility related so ominously to both.

The medical profession itself can do much to regain its lost prestige, if it will recast the code which condones so many abuses, and cultivate as general and normal characteristics the high ideals and the spirit of effectiveness which distinguish its more earnest members. But such a change, at the best, can only come slowly, without the external pressure of insistent public opinion and of adequate laws. Legislation on the lines that I have indicated is essential; and the need is urgent. This is not a case of a disorganized, demoralized profession which should be allowed to work out its own salvation, at its own expense; a profession inevitably works, for good or evil, at the expense of the public; and in this instance the cost is intolerable. It is paid every day in mutilated bodies, in wrecked constitutions, in stricken and embittered lives, and in death—a ghastly national tax which an awakened civilized nation is bound, in the name of humanity, to repeal.

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[1] *Charities and the Commons,* July 4, 1908.

# APPENDIX A

## THE CARNEGIE FOUNDATION REPORT UPON MEDICAL EDUCATION IN THE UNITED STATES AND CANADA

The following is from the Introduction to *Carnegie Foundation Bulletin* No. 4, by President Henry S. Pritchett. This bulletin, to which repeated references have been made in the foregoing pages, has perhaps received a greater degree of publicity than any other publication dealing exclusively with a medical subject. Articles either by Mr. Flexner or based upon his work have already appeared in the *Atlantic Monthly*, the *Review of Reviews*, the *Literary Digest*, the New York *Sunday Times* and scores of other prominent periodicals. Hundreds of extracts and editorials commenting upon the report have also appeared, indicating a public tension that the medical profession have been forced to acknowledge, and the end is not yet.

Bulletin No. 4 may be had from the Carnegie Foundation, 576 Fifth Avenue, New York, upon written request, with seventeen cents enclosed for postage.

" When the work of the Foundation began five years ago the trustees found themselves intrusted with an endowment to be expended for the benefit of teachers in the colleges and universities of the United States, Canada, and Newfoundland. It required but the briefest examination to show that amongst the thousand institutions in English-speaking North America which bore the name college or university there was little unity of purpose or of standards. A large majority of all the institutions in the United States bearing the name college were really concerned with secondary education.

" Under these conditions the trustees felt themselves compelled to begin a critical study of the work of the college and the university in different parts of this wide area, and to commend to colleges and universities the adoption of such standards as would intelligently relate the college to the secondary school and to the university. While the Foundation has carefully refrained from attempting to become a standardizing agency, its influence has been thrown in the direction of a differentiation between the secondary school and the college, and between the college and the university. It is indeed only one of a number of agencies, including the stronger colleges and universities, seeking to bring about in American education some fair conception of unity and the attainment ultimately of a system of schools intelligently related to each other and to the ambitions and needs of a democracy.

"At the beginning, the Foundation naturally turned its study to the college, as that part of our educational system most directly to be benefited by its endowment. Inevitably, however, the scrutiny of the college led to the consideration of the relations between the college or university and the professional schools which had gathered about it or were included in it. The confusion found here was quite as great as that which exists between the field of the college and that of the secondary school. Colleges and universities were discovered to have all sorts of relations to their professional schools of law, of medicine, and of theology. In some cases these relations were of the frailest texture, constituting practically only a license from the college by which a proprietary medical school or law school was enabled to live under its name. In other cases the medical school was incorporated into the college or university, but remained an *imperium in imperio,* the college assuming no responsibility for its standards or its support. In yet other cases the college or university assumed partial obligation of support, but no responsibility for the standards of the professional school, while in only a relatively small number of cases was the school of law or of medicine an integral part of the university, receiving from it university standards and adequate maintenance. For the past two decades there has been a marked tendency to set up some connection between universities and detached medical schools, but under the very loose construction just referred to.

" Meanwhile the requirements of medical education have enormously increased. The fundamental sciences upon which medicine depends have been greatly extended. The laboratory has come to furnish alike to the physician and to the surgeon a new means for diagnosing and combating disease. The education of the medical practitioner under these changed conditions makes entirely different demands in respect to both preliminary and professional training.

" Under these conditions and in the face of the advancing standards of the best medical schools, it was clear that the time had come when the relation of professional education in medicine to the general system of education should be clearly defined. The first step toward such a clear understanding was to ascertain the facts concerning medical education and the medical schools themselves at the present time. In accordance, therefore, with the recommendation of the president and the executive committee, the trustees of the Carnegie Foundation at their meeting in November, 1908, authorized a study and report upon the schools of medicine and law in the United States and appropriated the money necessary for this undertaking. The present report upon medical education, prepared, under the direction of the Foundation, by Mr. Abraham Flexner, is the first result of that action.

" No effort has been spared to procure accurate and detailed information as to the facilities, resources, and methods of instruction of the medical schools. They have not only been separately visited, but every statement made in regard to each detail has been carefully checked with the data in possession of the American Medical Association, likewise obtained by personal inspection, and with the records of the Association of American Medical Colleges, so far as its membership extends. The details as stated go forth with the sanction of at least two, and frequently more, independent observers.

" In making this study the schools of all medical sects have been included. It is clear that so long as a man is to practise medicine the public is equally concerned in his right preparation for that profession, whatever he call himself,—allopath, homœopath, eclectic, osteopath, or what not. It is equally clear that he should be grounded in the fundamental sciences upon which medicine rests, whether he practises under one name or under another.

" The attitude of the Foundation is that all colleges and universities, whether supported by taxation or by private endowment, are in truth public service corporations, and that the public is entitled to know the facts concerning their administration and development, whether those facts pertain to the financial or to the educational side. We believe, therefore, that in seeking to present an accurate and fair statement of the work and the facilities of the medical schools of this country, we are serving the best possible purpose which such an agency as the Foundation can serve; and, furthermore, that only by such publicity can the true interests of education and of the universities themselves be subserved. In such a reasonable publicity lies the hope for progress in medical education.

" The striking and significant facts which are here brought out are of enormous consequence not only to the medical practitioner, but to every citizen of the United

States and Canada; for it is a singular fact that the organization of medical education in this country has hitherto been such as not only to commercialize the process of education itself, but also to obscure in the minds of the public any discrimination between the well-trained physician and the physician who has had no adequate training whatsoever. As a rule, Americans, when they avail themselves of the services of a physician, make only the slightest inquiry as to what his previous training and preparation have been. One of the problems of the future is to educate the public itself to appreciate the fact that very seldom, under existing conditions, does a patient receive the best aid which it is possible to give him in the present state of medicine, and that this is due mainly to the fact that a vast army of men is admitted to the practice of medicine who are untrained in sciences fundamental to the profession and quite without a sufficient experience with disease. A right education of public opinion is one of the problems of future medical education.

"The significant facts revealed by this study are:—

"(1) For twenty-five years past there has been an enormous over-production of uneducated and ill-trained medical practitioners. This has been in absolute disregard of the public welfare and without any serious thought of the interests of the public. Taking the United States as a whole, physicians are four or five times as numerous in proportion to population as in older countries like Germany.

"(2) Over-production of ill-trained men is due in the main to the existence of a very large number of commercial schools, sustained in many cases by advertising methods through which a mass of unprepared youth is drawn out of industrial occupations into the study of medicine.

"(3) Until recently the conduct of a medical school was a profitable business, for the methods of instruction were mainly didactic. As the need for laboratories has become more keenly felt, the expenses of an efficient medical school have been greatly increased. The inadequacy of many of these schools may be judged from the fact that nearly half of all our medical schools have incomes below $10,000, and these incomes determine the quality of instruction that they can and do offer.

"Colleges and universities have in large measure failed in the past twenty-five years to appreciate the great advance in education and the increased cost of teaching it along modern lines. Many universities desirous of apparent educational completeness have annexed medical schools without making themselves responsible either for the standards of the professional schools or for their support.

"(4) The existence of many of these unnecessary and inadequate medical schools has been defended by the argument that a poor medical school is justified in the interest of the poor boy. It is clear that the poor boy has no right to go into any profession for which he is not willing to obtain adequate preparation; but the facts set forth in this report make it evident that this argument is insincere, and that the excuse which has hitherto been put forward in the name of the poor boy is in reality an argument in behalf of the poor medical school.

"(5) A hospital under complete educational control is as necessary to a medical school as is a laboratory of chemistry or pathology. High grade teaching within a hospital introduces a most wholesome and beneficial influence into its routine. Trustees of hospitals, public and private, should therefore go to the limit of their authority in opening hospital wards to teaching, provided only that the universities secure sufficient funds on their side to employ as teachers men who are devoted to clinical science.

"In view of these facts, progress for the future would seem to require a very much smaller number of medical schools, better equipped and better conducted than our schools now as a rule are; and the needs of the public would equally require that we have fewer physicians graduated each year, but that these should be better educated and better trained. With this idea accepted, it necessarily follows that the medical school will, if rightly conducted, articulate not only with the university, but with the general system of education. Just what form that articulation must take will vary in the immediate future in different parts of the country. Throughout the eastern and central states the movement under which the medical school articulates with the second year of the college has already gained such impetus that it can be regarded as practically accepted. In the southern states for the present it would seem that articulation with the four-year high school would be a reasonable starting-point for the future. In time the development of secondary education in the south and the growth of the colleges will make it possible for southern medical schools to accept the two-year college basis of preparation. With reasonable prophecy the time is not far distant when, with fair respect for the interests of the public and the need for physicians, the articulation of the medical school with the university may be the same throughout the entire country. For in the future the college or the university which accepts a medical school must make itself responsible for university standards in the medical school and for adequate support for medical education. The day has gone by when any university can retain the respect of educated men, or when it can fulfil its duty to education, by retaining a low grade professional school for the sake of its own institutional completeness.

"If these fundamental principles can be made clear to the people of the United States and of Canada, and to those who govern the colleges and the universities, we may confidently expect that the next ten years will see a very much smaller number of medical schools in this country, but a greatly increased efficiency in medical education, and that during the same period medical education will become rightly articulated with, and rightly related to, the general educational system of the whole country.

" In the suggestions which are made in this report looking toward the future development of medicine, it ought to be pointed out that no visionary or impossible achievement is contemplated. It is not expected that a Johns Hopkins Medical School can be erected immediately in cities where public support of education has hitherto been meagre. Nevertheless, it is quite true that there is a certain minimum of equipment and a minimum of educational requirement without which no attempt ought to be made to teach medicine. Hitherto not only proprietary medical schools, but colleges and universities, have paid scant attention to this fact. They have been ready to assume the responsibility of turning loose upon a helpless community men licensed to the practice of medicine without any serious thought as to whether they had received a fair training or not. To-day, under the methods pursued in modern medicine we know with certainty that a medical school cannot be conducted without a certain minimum of facilities. The institution which attempts to conduct a school below this plane is clearly injuring, not helping, civilization. In the suggestions which are made in this report as to what constitutes a reasonable minimum no visionary ideal has been pursued, but only such things have been insisted upon as in the present light of our American civilization every community has a right to demand of its medical school, if medicine is to be taught at all.

" The development which is here suggested for medical education is conditioned largely upon three factors: first, upon the creation of a public opinion which shall discriminate between the ill trained and the rightly trained physician, and which will also insist upon the enactment of such laws as will require all practitioners of medicine, whether they belong to one sect or another, to ground themselves in the fundamentals upon which medical science rests; secondly, upon the universities and their attitude toward medical standards and medical support; finally, upon the attitude of the members of the medical profession toward the standard of their own practice and upon their sense of honor with respect to their own profession.

" These last two factors are moral rather than educational. They call for an educational patriotism on the part of the institutions of learning and a medical patriotism on the part of the physician.

" By educational patriotism I mean this: a university has a mission greater than the formation of a large student body or the attainment of institutional completeness, namely, the duty of loyalty to the standards of common honesty, of intellectual sincerity, of scientific accuracy. A university with educational patriotism will not take up the work of medical education unless it can discharge its duty by it; or if, in the days of ignorance once winked at, a university became entangled in a medical school alliance, it will frankly and courageously deal with a situation which is no longer tenable. It will either demand of its medical school university ideals and give it university support, or else it will drop the effort to do what it can only do badly.

" By professional patriotism amongst medical men I mean that sort of regard for the honor of the profession and that sense of responsibility for its efficiency which will enable a member of that profession to rise above the consideration of personal or of professional gain. As Bacon truly wrote, ‘ Every man owes a duty to his profession,’ and in no profession is this obligation more clear than in that of the modern physician. Perhaps in no other of the great professions does one find greater discrepancies between the ideals of those who represent it. No members of the social order are more self-sacrificing than the true physicians and surgeons, and of this fine group none deserve so much of society as those who have taken upon their shoulders the burden of medical education. On the other hand, the profession has been diluted by the presence of a great number of men who have come from weak schools with low ideas both of education and of professional honor. If the medical education of our country is in the immediate future to go upon a plane of efficiency and credit, those who represent the higher ideals of the medical profession must make a stand for that form of medical education which is calculated to advance the true interests of the whole people and to better the ideals of medicine itself.

“ There is raised in the discussion of this question a far-reaching economic problem to which society has as yet given little attention; that is to say, what safeguards may society and the law throw about admission to a profession like that of law or of medicine in order that a sufficient number of men may be induced to enter it and yet the unfit and the undesirable may be excluded?

“ It is evident that in a society constituted as are our modern states, the interests of the social order will be served best when the number of men entering a given profession reaches and does not exceed a certain ratio. For example, in law and medicine one sees best in a small village the situation created by the over-production of inadequately trained men. In a town of two thousand people one will find in most of our states from five to eight physicians where two well trained men could do the work efficiently and make a competent livelihood. When, however, six or eight ill trained physicians undertake to gain a living in a town which can support only two, the whole plane of professional conduct is lowered in the struggle which ensues, each man becomes intent upon his own practice, public health and sanitation are neglected, and the ideals and standards of the profession tend to demoralization.

" A similar state of affairs comes from the presence of too large a number of ill trained lawyers in a community. When six or eight men seek to gain their living from the practice of the law in a community in which, at the most, two good lawyers could do all the work, the demoralization to society becomes acute. Not only is the process of the law unduly lengthened, but the temptation is great to create business. No small proportion of the American lack of respect for the law grows out of the presence of this large number of ill trained men seeking to gain a livelihood from the business which ought in the nature of the case to support only a much smaller number. It seems clear that as nations advance in civilization, they will be driven to throw around the admission to these great professions such safeguards as will limit the number of those who enter them to some reasonable estimate of the number who are actually needed. It goes without saying that no system of standards of admission to a profession can exclude all the unfit or furnish a perfect body of practitioners, but a reasonable enforcement of such standards will at least relieve the body politic of a large part of the difficulty which comes from over-production and will safeguard the right of society to the service of trained men in the great callings which touch so closely our physical and political life.

" The object of the Foundation in undertaking studies of this character is to serve a constructive purpose, not a critical one. Unless the information here brought together leads to constructive work, it will fail of its purpose. The very disappearance of many existing schools is part of the reconstructive process. Indeed, in the course of preparing the report a number of results have already come about which are of the highest interest from the constructive point of view. Several colleges, finding themselves unable to carry on a medical school upon right lines, have, frankly facing the situation, discontinued their medical departments, the result being a real gain to medical education. Elsewhere, competing medical schools which were dividing the students and the hospital facilities have united into a single school. In still other instances large sums of money have been raised to place medical education on a firmer basis.

" In the preparation of this report the Foundation has kept steadily in view the interests of two classes, which in the over-multiplication of medical schools have usually been forgotten,—first, the youths who are to study medicine and to become the future practitioners, and, secondly, the general public, which is to live and die under their ministrations.

" No one can become familiar with this situation without acquiring a hearty sympathy for the American youth, who, too often the prey of commercial advertising methods, is steered into the practice of medicine with almost no opportunity to learn the difference between an efficient medical school and a hopelessly inadequate one. A clerk who is receiving $50 a month in the country store gets an alluring brochure which paints the life of the physician as an easy road to wealth. He has no realization of the difference between medicine as a profession and medicine as a business, nor as a rule has he any adviser at hand to show him that the first requisite for the modern practitioner of medicine is a good general education. Such a boy falls an easy victim to the commercial medical school, whether operating under the name of a university or college, or alone.

" The interests of the general public have been so generally lost sight of in this matter that the public has in large measure forgotten that it has any interests to protect. And yet in no other way does education more closely touch the individual than in the quality of medical training which the institutions of the country provide. Not only the personal well-being of each citizen, but national, state, and municipal sanitation rests upon the quality of the training which the medical graduate has received. The interest of the public is to have well trained practitioners in sufficient number for the needs of society. The source whence these practitioners are to come is of far less consequence.

" In view of this fact, the argument advanced for the retention of medical schools in places where good clinical instruction is impossible is directly against the public interest. If the argument were valid, it would mean that the sick man is better off in the hands of an incompetent home-grown practitioner than in those of one well trained in an outside school. Such an argument ought no longer to blind the eyes of intelligent men to the actual situation. Any state of the Union or any province of Canada is better off without a medical school than with one conducted in a commercial spirit and below a reasonable plane of efficiency. No state and no section of a state capable of supporting a good practitioner will suffer by following this policy. The state of Washington, which has no medical school within its borders, is doubtless supplied with as capable and well trained a body of medical practitioners as is Missouri with its eleven medical schools or Illinois with its fourteen.

" The point of view which keeps in mind the needs and qualifications of the medical student and the interests of the great public is quite a different one from that which the institution which conducts a medical department ordinarily occupies. The questions which look largest to the institutions are: Can we add a medical school to our other departments? and if so, where can we find the students? The questions which the other point of view suggests are: Is a medical school needed? Cannot those qualified to study medicine find opportunities in existing schools? If not, are the means and facilities at hand for teaching medicine on a right basis?

"While the aim of the Foundation has throughout been constructive, its attitude toward the difficulties and problems of the situation is distinctly sympathetic. The report indeed turns the light upon conditions which, instead of being fruitful and inspiring, are in many instances commonplace, in other places bad, and in still others scandalous. It is nevertheless true that no one set of men or no one school of medicine is responsible for what still remains in the form of commercial medical education. Our hope is that this report will make plain once for all that the day of the commercial medical school has passed. It will be observed that, except for a brief historical introduction, intended to show how present conditions have come about, no account is given of the past of any institution. The situation is described as it exists to-day in the hope that out of it, quite regardless of the past, a new order may be speedily developed. There is no need now of recriminations, over what has been, or of apologies by way of defending a régime practically obsolete. Let us address ourselves resolutely to the task of reconstructing the American medical school on the lines of the highest modern ideals of efficiency and in accordance with the finest conceptions of public service."

# APPENDIX B

## "UNNECESSARY OPERATIONS THE OPPROBRIUM OF MODERN SURGERY"

A letter from Dr. G. H. Balleray (of Paterson, New Jersey), published in the *Medical Record*, February 9, 1907.

"Sir:—It cannot be denied that at the present day many operations are performed that are not only unnecessary but unjustifiable. This is especially true of abdominal and pelvic surgery. Time was when ovaries were removed by the peck for all sorts of nervous disturbances, which had no more to do with the condition of the ovaries than with the change of the moon. This was the era of Battery's so-called 'normal ovariotomy,' than which no greater outrage could be perpetrated upon a confiding woman. To-day it is not fashionable to remove the ovaries for an attack in which the globus hystericus is the most prominent symptom, but those organs are still subjected to certain operative procedures for pathological conditions which exist only in the mind of the operator. At times the ovary is removed for what the operator is pleased to dignify by the term of 'ovarian cyst.' This cyst is sometimes no larger than a cherry, and very often much smaller. At times the ovary is not removed, but the cyst is punctured with knife or cautery, and the Fallopian tube, which he claims is the seat of salpingitis, but which may be perfectly normal, is resected. What justification is there for opening a woman's abdomen for such conditions? The operator may justify himself by saying that the woman suffered from pelvic pain which justified the operation. Now, every experienced gynecologist knows that this is not true; such conditions do not give rise to pain. If the woman really suffers pain she is probably a neurotic subject, whose pains and aches are due to anæmia and general malnutrition. If she did not have pain in her pelvis she would have it somewhere else. Anstie has truly said 'neuralgia is the cry of the nerves for healthy blood,' and such patients require iron, fresh air, sunshine, and good food—not a mutilating operation.

"The uterine adnexæ are not the only organs subject to atrocious assault; the uterus itself comes in for more than its fair share. To say nothing about the injury so often inflicted on it by the ignorant, through bungling attempts at dilation and curettage, or maladroit trachelorrhaphy, the organ is often extirpated for no apparent reason, except the undying fondness of some man for notoriety or money. The uterus is often removed for a small myoma the size of a walnut. The writer saw two such cases during the past month. In one case abdominal hysterectomy was done by a prominent New York surgeon; in the other an experienced man performed a vaginal hysterectomy, which was attended by so much hemorrhage that he opened the abdomen in the hope of controlling it. In this he was not successful; more or less bleeding continued until the death of the patient about two days later. At the December meeting of the Obstetrical and Gynecological Section of the New York Academy of Medicine, Dr. Henry C. Coe protested against the performance of hysterectomy for insignificant benign growths, and the writer, in indorsing Dr. Coe's protest, stated that in his opinion such operations should be looked upon as pure surgical quackery. The over-zealous gynecologist seems to be constantly in search of an opportunity to extirpate the uterus. If a woman has a large subinvoluted uterus with catarrhal endometritis attended by profuse menstruation, he scrapes the uterus and sends some of the scrapings to a personal friend—a *soi-distant* microscopist, who would not know a cancer cell from a load of hay. His friend, the 'microscopist,' having been told what the would-be operator 'fears,' proceeds to find 'suspicious-looking cells.' That is enough—out comes that uterus. Again, a woman has a badly lacerated cervix with ectropion and erosion. The cervix has certainly an angry look, but the experienced man knows that it is not cancerous. He has operated on scores, yea perhaps hundreds of similar cases by Emmet's method, and they have been permanently cured. But our enthusiastic confrère is ultra scientific. He is not willing to trust to his naked eye, or anybody else's naked eye; so he chips off a piece of the cervix and sends it to the same microscopist, being careful to tell him what he himself thinks. The microscopist is either again 'suspicious' or 'in doubt,' and, as Cavendish says in regard to whist, 'when in doubt play trumps,' our friend plays trumps, and out comes that uterus also. Far be it from the writer to disparage the well-trained, intelligent, honest microscopist, whose assistance is invaluable in many doubtful cases. He makes reference to those who, without proper qualifications, pose as experts, and whose opinions are often used by those who are over anxious to operate as a makeweight in overcoming the objections of patients or of the family physician, to operations which should never be performed. In a paper entitled 'A Plea for Early Operation in Cancer of the Womb,' the writer has denounced the criminal neglect and procrastination which allows a woman with cancer of the uterus to drift into an incurable state before she is referred to an operative gynecologist, and he sincerely hopes that nothing contained in this communication will detract from the force of what he then said. Every available means at our command should be brought to bear that may enable us to diagnose cancer in its incipiency.

"It is one thing to make an honest search for the truth in the interests of the patient and quite another thing to play the charlatan while pretending to base one's practice upon scientific accuracy. Next to the uterus and adnexæ, the appendix vermiformis and kidney are the most abused organs. With some practitioners every belly ache is called appendicitis, and an operation for the removal of a normal appendix follows forthwith. The writer has seen the appendix removed in a number of cases in which it was absolutely normal, and within the past five years he has been consulted by many women who had been told that they should submit to an operation for what was said to be appendicitis, but the subsequent history showed that no operation was necessary in most of the cases; and in those in which abdominal section was necessary it was found that the appendix had nothing to do with the symptoms complained of. In times gone by, when a physician was too ignorant to make a diagnosis, he labelled the disease 'malaria,' and everybody was satisfied. Now the so-called surgeon calls everything appendicitis, and cuts out the appendix, with equally gratifying results. The furor for unnecessary operations has spread to the laity, and the cheerfulness with which the would-be fashionable man parts with his appendix is only equalled by the abandon with which the modern woman submits to the evisceration of her pelvis by her pet gynecologist. Practising fantastic operations on the kidney keeps some men in the profession busy. A poor, thin, neurotic woman, whose circumrenal fat has been absorbed, leaving the kidney anchored only by its moorings, consults one of these men. With wonderful sagacity he diagnoses 'floating kidney' and at once performs nephrorrhaphy. If from rest in bed and general improvement in health therefrom a layer of fat is deposited around the kidney the woman is cured, and the doctor gives the credit to the operation.

"If the patient does not gain flesh after the operation, in a few months the kidney 'floats' again as badly as ever. But the operator may remain ignorant of the fact, for the patient may consult somebody with common sense enough to put her in bed, feed her generously, remove all sources of worry, and thus put her in the way of gaining flesh, and after a time the kidney stays where it belongs. Splitting the capsule has been advised and practised as a panacea in Bright's disease. The writer has no knowledge of any authentic case in which a cure has been effected, but he knows of one case reported as a cure, although the patient died a short time after the operation, and the kidneys are in pickle in a jar which is the property of a well-known pathologist. Prostatectomy seems to be the latest fad, and the man of sixty who is still carrying his prostate where Nature intended that he should is looked down upon by his contemporaries who have yielded theirs as a contribution to extend the popularity of this surgical innovation. Let us hope that the interest shown in the prostate may result in giving a much needed rest to the appendix and the kidney.

"From long experience the writer is fully aware of the difficulties and responsibilities involved in the diagnosis and treatment of serious abdominal and pelvic lesions, and is ever ready to deal charitably with the errors of judgment of a professional brother. We all make mistakes—we are all liable to sins of omission and sins of commission; but there is a vast difference between the honest mistakes of the well-trained, intelligent surgeon, who looks upon every case with an eye single to the good of the patient, and the stupid blunders of the inexperienced or meddlesome operator, whose ignorance of pathology and of the natural history of disease causes him to see in every case an indication for operation, and who is ever willing to sacrifice the good of the patient to his own love of self aggrandizement."

# APPENDIX C

## A VISIT TO THE MAYOS' CLINIC (ROCHESTER, MINN.)

From an article by Dr. W. F. Church (of Greely, Colorado), contributed to the *American Journal of Clinical Medicine*, May, 1908.

"To be fully up-to-date it is now considered necessary to make a pilgrimage to Rochester, Minnesota, at present the Mecca of American Surgery, and there sit at the feet of the two Mayo Brothers and marvel at their wonderful work. The idea that these men best represent the highest accomplishments in the technique and results of American surgery seems to have pervaded the surgical mind of Europe, for famous surgeons across the Atlantic pass by the great medical centres of the East, or maybe just tarry briefly on their way to a small, little-known city in the great Northwest.

* * *

"The Mayos are the chief benefactors of the city and its chief attraction. They have stemmed and reversed the current of surgical cases setting toward the great cities, and directed it toward their own little town. It has been no little task to prove to people that the highest skill can be found elsewhere than in a metropolis.

* * *

"St. Mary's Hospital is not particularly imposing in comparison with like institutions in large cities, but it is beautifully located at the west end of the city, the country ahead being not only pleasant to look upon but affording an abundance of untainted air. Its capacity is 180 beds, all used for surgical cases. The operating rooms, two in number, with a sterilizing room between, are located on the fourth, or top, floor, fronting to the north, so that light is quite uniform. An adjacent room is used as a waiting room by visiting surgeons. Here men from many sections of this country, as well as Canada, meet on common ground. They are all learners. Here is found the would-be surgeon, the man of moderate experience, and the expert operator. Not one of them can go away without having gained information.

" When preparations for an operation are completed a bell is touched to summon the visitors, who file into the room and mount the L-shaped platform made of steel with large connecting brass tubing for railing, furnishing two rows of seats, the rear considerably elevated above that in front. An excellent view is thus afforded of operations not performed in deep cavities. Both surgeons may be operating at the same time, and the visitor may select the operation that he cares most to see performed. Most of the time, however, while one surgeon is operating, a patient is being prepared in the operating room, so the visitor can, by passing first to one, then to the second and third room, witness from two-thirds or three-fourths of the operative work of both men. If all operations could be performed in the same length of time all could be witnessed, but a prolonged operation breaks the alternation.

" In most, if not quite all, other hospitals in which I have witnessed the procedure it is the custom to anæsthetize the patient in a room adjacent to the operating room. In St. Mary's Hospital the patient, if able, walks into the operating room, from which visitors are excluded, and is thus given a chance to view the surroundings with the view of allaying trepidation and fear. Ether is the anæsthetic of choice, and is given by the drop-method by a trained nurse thoroughly versed in anæsthetizing. Nurses are preferred to doctors for this work as they are less liable to neglect their work because of interest in the operation. This clinic is entitled to much praise for what it has done to popularize the drop-method of giving ether. In 1906, out of a total of 3915 operative cases ether was administered 3853 times.

"Every visitor not previously instructed and not knowing what to expect is astonished at the amount of work done. It seemed to be a very common experience to operate on 20 patients in a day. One day I saw 23 cases posted for operation. In 1907, there were 4811 operative cases in the hospital, an increase of nearly 900 over the number of the previous year. According to one visiting surgeon who had come to Rochester several times, the clinic had doubled since his first visit of five or six years ago. It must be borne in mind that while other surgeons operate two or three days in the week, the Mayo Brothers operate six days in the week. I did not learn whether they stopped for holidays.

"It does not take one long to discover that the celebrated surgeons have their offices only a block away from the hotel, and that Drs. W. J. Mayo, C. H. Mayo, Judd, Graham, and Plummer are the members of a firm equipped to combat any disease on earth. Drs. Graham and Plummer are internists. The firm, so I understand, employ a corps of about twenty physicians, largely for the purpose of diagnosis. On reaching Rochester it is necessary for a patient to go to the office and register, when his case is taken under consideration. It may be two days or two weeks before a final decision is reached. The number of people was a surprise to the uninitiated. I was told by one of the employees that some days there were two or three hundred in attendance for consultation. It must not be understood that these are all new patients, for some must come for several days before an operation is decided upon. Since last summer there were at least a thousand new patients each month. Of this number only about two out of five were finally operated upon.

"It is well known that a man may be a good operator but a poor diagnostician, and the time spent in operating is very short compared with the time spent in diagnosis. With their trained assistants the Mayos are able to employ all known methods of arriving at a conclusion. If the benignancy of a tumor incised in the operating room is doubtful, the expert pathologist reports in a few minutes and operative procedure is carried out as needed. One stops to wonder whether a lone surgeon can compete with such a trained body of men, and one also wonders what would happen if capitalists should decide to start a great institution and employ experts in every line and highly trained operators. Medical journals might have something to say about medical trusts. Of late the small hospital and the occasional operator have been gaining ground. Which system will gain the greatest headway during the next decade?

"I asked a surgeon who had spent some time at Rochester, and who claimed the honor of having visited the chief clinics of this country and Europe, what he thought of the clinic of St. Mary's. 'The finest in the world,' he replied.

"I do not care to dispute his statement. If there is any place in this country and Europe where more or better surgery can be seen than at Rochester in a week's time, I do not know where it can be found.

"The visitor to Rochester cannot soon forget the courtesy extended to him in being permitted to witness such fine examples of surgical art."

To this interesting description the editor of *Clinical Medicine* adds the following comment:—

"The remarkable success of the Mayos' clinic, so it seems to the writer, must be ascribed, in part at least, to the wonderful organization of its clinical and diagnostic staff, and the perfection of detail with which it is enabled to grapple with every problem, so that the element of guesswork is eliminated so far as this is possible, *before* the operation instead of *after it*. In other words, this institution is a triumph of coöperation. What this group of physicians has succeeded in doing by working together to a common end, other physicians can do, even on a smaller scale."

# APPENDIX D

## "FRENZIED SURGERY OF THE ABDOMEN"

An article by Dr. J. W. Kennedy (of Philadelphia), published in the *New York Medical Journal*, November 23, 1907. (From the Clinic of Dr. Joseph Price.)

"After training for seven years under a great master, I find myself an earnest advocate for more apprenticeship.

"The great number of reoperations in which it has been my privilege to participate have suggested the title of this paper.

"Where does the education of the abdominal surgeon begin? Certainly not with the incision into the abdomen. It is with great apprehension and profound regret that we find such a large proportion of aspirants for surgery of the abdomen who have not the proper appreciation of the value of preliminary training in this great work.

"Were we to answer the question 'Where does the education of the laparotomist begin?' I would say with the examination of the female pelvis.

"In the last twenty thousand bimanual examinations in the Philadelphia Dispensary, we have had two aspirants for diagnostic advantages, while many thousands have witnessed the operations therefrom.

"Our intelligence in this field of work is not acquired along leisure lines or those most pleasant to follow. It is a great, grand, consistent work, punishing and rewarding in direct proportion to the ability of the operator. Nor do we think abdominal surgery a natural step in the progress of general surgery; but it is a delicate specialty so sensitive to insults and resentful to unsurgical procedures.

"Not from inspiration, but from perspiration, will you become a monarch in this work. I know no more earnest plea for more apprenticeship than a quotation from Doctor Price, who says: ‘ After entering the abdomen over twenty-four thousand times, I find myself a bitter critic of my work. Each operation is such an important object lesson and an appeal for more refined and completed work.’

“ One may be a brilliant operator yet a dangerous one. Surgical judgment is eminently the most important quality of an operation and must be born from personal experience and an exhaustive study of others’ works. Much of our literature on the surgery of the abdomen is a perfect bedlam of opinions of operators of little experience.

“ The beginner is abashed by contradictory ideas and procedures which have emanated from operators who are not familiar with pathological probabilities and possibilities of intra-abdominal conditions. We have too much literature on minor differences of operative technique, which is often a mere advertisement of the *I* and *My* procedure, and not enough on diagnosis and history of pathology. It will be a strong profession, indeed, when we are familiar with our surgical limitations and have learned that there is a definite lesson taught by every pathological lesion which revolts at unanatomical and unphysiological surgery. This would make the great specialty so beautiful and its punishment so bitter to the surgeon without refined attainments.

“ There are many small hospitals in our country without a resident physician, yet those institutions are filled with interesting surgical and medical material. With a respectful degree of courtesy to the great teaching institutions of our country, one cannot help but feel that the student is not sufficiently encouraged in the dispensary, hospital, and slum work of our large cities. Those who have had the wide experience of the general practitioner become the most accurate in the specialty. The surgeon must be familiar with pneumonia, pleurisy, typhoid fever, etc., and the internist must receive an apprenticeship as an assistant to some laparotomist.

"He must stand the fire of living pathology and learn therefrom a lesson of certainty on progression of many pathological conditions. He can thus obtain a biographical view and practically witness moving pictures of diseases.

"The operator's judgment emanates from a succession of mental photographs of a lesion, from the incipiency of disease to the *devastation* of viscera. When so often eye-witnesses of pathological conditions have we not a most defensible argument for our views?

"It is upon this ground that we dogmatically take our stand in those suppurative lesions whose signs and symptoms are not proportionate to the pathology witnessed at the operating table, and so make our appeal for early interference.

"The practitioner who follows his patient to the operating room always becomes an accomplished diagnostician and an ardent co-operator. Intra-abdominal surgery of the day is a crippled giant. The competent operator has so much more in his power than he is privileged to execute.

"Incompetent surgery has made the practitioner a doubting Thomas and results in a tardy diagnosis with high mortality.

"Over eighty per cent. of our appendical work for the past two months has been pus, gangrene, and peritonitis, which is a flagrant disgrace to the diagnostic ability of a large educational centre, and we can hope for little in the future, unless our leaders stand for first-hour operations.

"We had in the hospital at one time ten patients, on whom twenty-seven sections had been done, all pitiable examples of errors in diagnosis, incomplete surgical procedures, and frenzied surgical judgment from an anatomical, physiological and pathological standpoint.

" During the last six months nearly fifty per cent. of our work consisted of reoperations. Multiple scars marred the abdomen and were reproachful neglects of the untrained surgical mind. The sins of the operator had been visited upon the patient to the third, fourth and fifth scar. The patient had been a chronic invalid and often an unwilling victim of some drug habit.

" Surgical achievements of the competent operator are so often minimized by the incompetency of others. The complications incident to previous operations are a greater source of mortality than the lesion itself. Late and faulty diagnosis, incomplete procedures, and errors in judgment of pathological future have brought us mortality which is an insult to the advanced surgery of the day.

" The physiologists are demanding a revolution in the surgery of the upper abdomen. Their views demand more operative conservatism for visionary pathology. Much of their ground is well taken and strongly supported on a physiological and anatomical basis.

" Surgically the most important intra-abdominal work consists of the acute inflammatory lesions which confront us daily, and it is the management of these conditions on which the profession is much divided medically and surgically.

" Active suppurative lesions should be looked upon as emergency surgery and are as much a demand for early work as ectopic gestation, twisted pedicle, or strangulated hernia.

" Doctor Price's great work on acute suppurative lesions of the abdomen is a very strong plea for early and complete procedures. His results are a convincingly strong post on which to lean, and commend to us much denied surgical teaching. He says: ' In these conditions do not depend upon inflammatory walls and gravity for surgical consolation. The toilet of such lesions must be proportionate to the extent of the pathology. Partial toilets have a double mortality, primarily from filth and pathology not removed; secondly from post-operative complications (adhesions, etc.), and the multiple operations which follow.'

"Courteously and wisely we beginners ask our masters to take care of our mistakes, but greater humanitarians will our superiors be when their interest antedates our errors."

# APPENDIX E

## "SOME OF THE PROBLEMS OF THE INTERNIST WHICH CONCERN THE SURGEON"

From an article by Dr. J. F. Percy, President of the Illinois State Medical Society, read before the Meeting of the Society (Section on Medicine), May, 1906, and published in the *Illinois Medical Journal*, August, 1906. The major part of this paper, the nature of which is indicated in the title, has less interest for the general reader than the portion here presented, and hence is omitted. The same applies to the comments upon the paper by members of the Society, brief excerpts from which are also given.

"One of the problems of the medical profession to-day is the recent graduate who wants to do surgery. An equally important problem is the graduate of fifteen to thirty years ago who does not believe in surgery except as a last resort. The chief ambition of the recent graduate of my day was to do obstetrics and treat the diseases incident thereto. Good work was finally to obtain for him, as its reward, a reputation which would bring him money and a better reputation. The average graduate of to-day is looking to surgery as the most available means for immediate fame. The average older practitioner, whose medical horizon as to the possibilities of good surgery has not been greatly widened since leaving college, sees in these efforts of the youthful surgeon only the confirmation of his opinion that the surgery of to-day, after all, has no more to offer than it did in the days of his first medical observations. Unfortunately, there is a large number of both classes of these men in nearly every community, and they are doing more to prevent the real advance of our profession as a whole than any other class. The explanation is that they both lack the same thing, viz., a wider experience.

"There are too many men going into surgery as soon as they leave the medical school. I met one of them a few years ago. He had had his diploma just two weeks. He was an average graduate of a medical school with a good reputation. This young man had not prepared himself specially for anything but good average work. He had not had the training of the average hospital interne, he had not served as assistant to a real surgeon, he had not gotten up his surgical technique by animal experimentation, he knew nothing of the practical application of asepsis or even of antisepsis, neither had he learned in the great school of general practice; yet this doctor, who was just two weeks out of the opera chairs of his medical school, announced to me that he was ready to cut anything. And he did. Circumstances favored him so that he got surgical cases, and for a year or two he was literally doing surgery. Is he doing surgery to-day? No! Surgery has done him! He is in a position now where he has to commence all over again, if he wants to be a surgeon. But he probably never will. If the actual results of this man's work, while he was attempting to practise surgery, could be known, it would be a record heart-rending in the extreme. Some of you may say that he was a fool. No, he was not. If I thought he were, I would not have made him a part of this paper. Neither would I have mentioned this case if it were an isolated or uncommon one. But what I have just described is being enacted in scores of places not only in this state, but in every one of our states. If life and suffering count for anything, as they do, then this is a condition of affairs that, to put it mildly, is unfortunate for the most desirable and truest advance of both internal medicine and surgery.

“The explanation of this legalized assassin’s opportunities for carrying on his ignorantly based work is two-fold: First, the present-day medical school, and second, the internal medicine man. First, as to the medical school. I can best say what I believe should be said by describing a lecture heard within the year delivered to the senior class of a leading medical school in one of our largest cities. The subject of the lecture was the operations on the stomach. Practically all of the possible operations on this viscus were described as found in the ordinary and average text-book to-day. No attempt was made in the lecture to furnish guides as to the best operation to select in a given case of disease of the stomach. Not one word as to its dangers, and the pity of it all was that these young men were left with the impression that operations were easy. I might say that this is also one of the grievous faults of our modern text-books and even of many of our modern surgical authorities. The surgeon and the surgical writer forget too often that what is easy for him, after a ripe surgical experience, may be a veritable Waterloo when attempted by the novice. But, second, these errors of the teachers and the text-books, in this particular, could not do the harm that is being done to medicine to-day were it not for the laxity of the general medicine man, who is neglecting to diagnose certain very common surgical diseases, and, with it, failing to know what real surgery can do and is doing for their cure. In a community this failure on the part of a man who, because of the excellence of his previous work along general medical lines, has earned a good reputation, is most lamentable. It gives the illy prepared surgeon the opportunity he covets, and which he would not have had if his medical competitor had not depended too much on the symptoms and their relief from within the confines of his medical case.

"Many general practitioners seem to be acting on the assumption that surgery has already usurped the whole field of medical practice. It never can, and from the very nature of disease and diseased processes never will. Surgery has a glitter that will always be attractive to every thinking mind. Part of this is due to the fact that the cases in which it is applicable are comparatively rare. In an office where a large number of patients are seen each day, experience has shown that of every twelve examined but one will prove to be a subject for the knife. When this is fully realized, it will stop the rush on the part of so many, especially of the younger medical men, into surgery, because of the apparent, but not real, tendency of medical practice to-day to go that way. It has always been true, and it always will be true, that surgeons are born and not made. The wonderful art of the schools can make a man look like a surgeon for a time, perhaps; but in the light of the years he can maintain that right only by proving it.

"To-day, with all the very apparent progress in surgery, if one will but notice, there are only a few real surgeons. There are only a limited number of names in any country that by common consent stand for and deserve the name of surgeon. There are no more genuine surgeons to-day, according to population, than there were fifty or one hundred years ago. At that time each state had a very few men who, by common consent, were recognized by the profession and the public as surgeons. This is still true, and probably will remain true for at least many generations of men. In spite of this, with the advent of antisepsis which made surgery look so easy, hundreds rushed in where previously even angels feared to tread. But the profession and the public of to-day are slowly learning, as the profession and public learned in the years immediately following the advent of anæsthetics, that power to operate without pain on the part of the patient did not prevent the common sequel of operations in the days preceding anæsthetics. Freedom from pain did not prevent deaths from shock, from sepsis, and from bad surgical judgment. All of which holds true to-day, with the addition that, in these latter days, to the freedom from operative pain has been added, in many instances, the freedom from sepsis. But it takes more than an anæsthetized patient whose wounds are to heal without infection to demonstrate that the operator has a born right to the name of surgeon. Without good surgical judgment, no man can be a surgeon in the best sense of the word, no matter what his education, his opportunities, his experience, or his location."

From the comments upon Doctor Percy's paper, as reported in the *Illinois Medical Journal.*

Dr. Arthur Dean Bevan (of Chicago):—

"There are a few points in connection with this paper on which I wish to speak. First in regard to the young medical man who is attempting to do surgical work. I always felt that the best solution of this problem is found in demanding a hospital training for our young medical men. As a matter of fact, the dental graduate enters on his actual work of practice very much better prepared to do his work than does the young medical man, because the latter is without any training which fits him to meet the conditions as he must find them. The young dentist actually does a lot of clinical work before he graduates; that is not true of the medical man, unless he has served a hospital interneship. I firmly believe that the time is coming in this country, as it has already come in Germany, when, before a man can graduate in medicine and take an examination which will entitle him to practise, he will be compelled to take at least one year in a hospital, serving as an assistant under some good man. That is the solution of the problem.

"I do not believe that Dr. Percy is right when he says that surgeons are born, not made. He is in error. It is only necessary to cite the fact that Billroth filled almost every large surgical clinic in Germany and Austria with his students, which proves that it is the master who makes the man. The students of Billroth were not born surgeons, but they were made surgeons by being brought to see surgical work done by a master. That is the way in which this question will have to be solved in this country. Our young men must have the opportunity of working under masters in surgery. In the evolution of medicine as a whole in this country there are bound to be lines which divide the practitioners into specialists. The known facts of medicine are not so many but that they can be grasped and arranged systematically by any well-equipped brain.

"I do not agree at all with the idea that there must be only a few surgeons. I think the medical man of the future, as was expressed recently by Doctor McBurney, will be a well-qualified internist who can operate. It will be well enough in large communities like Chicago and New York, or towns of two or three hundred thousand population, to have the medical men divided into groups, that is, to have specialists, but in the ordinary practice throughout the United States, in cities of ten or twenty thousand population, the best doctor is the general practitioner, the man who can treat typhoid and appendicitis, pneumonia and empyema, the man who can cover the ground formerly covered by the old-fashioned country doctor, and who is also qualified to operate. These men do better work in handling a given thousand cases than would be done under the same conditions by ten different specialists. They make fewer mistakes and do less unnecessary work. They will be the medical men of the future."

Dr. E. J. Brown (of Decatur, Illinois):—

"I agree with Doctor Bevan that a surgeon is not necessarily born. As a rule, he is made. The best thing, however, that ever can happen to the practitioner of medicine is to find his limitations. We all know that an immense lot of surgery, and very poor surgery at that, is being done everywhere even by men of good reputations, and I think that when every man reaches the point where he can decide in what particular field he can do the best work, he will have reached the happiest moment of his life."

Doctor Brown (of De Kalb, Illinois):—

"No man has any right to be a surgeon unless he has been a general practitioner. He bears the same relation to the building as the man who mixes the mortar does to the architect. He can do the work but he is not competent to make the diagnosis. If you have a case of placenta prævia and call in a surgeon, what does he know about it? It is the general practitioner who is competent to make the diagnosis, and it is the surgeon who is competent to do the surgical work. Many men do surgery who are not surgeons at all. They are bunglers. They have not the necessary tact. The man in the country often performs surgical operations of all kinds just as well as does the specialist in the large city. I believe that the general practitioner of experience is in a very much better position to make a diagnosis than is the specialist surgeon, who looks at the case from one standpoint only, and who sometimes performs operations that never ought to be performed.

"Within the last six months I have seen two instances in Chicago where an appendix was removed that was not diseased at all. The general practitioner would not have done this, but if the appendix is diseased, he can remove it just as well as the surgeons in Chicago."

Doctor Percy (in conclusion):—

"I appreciate very much the kindness with which this section has received my paper. I believe, however, that most of the points brought out in the discussion were covered in the paper. The point made by Dr. Bevan that Billroth made surgeons in Europe undoubtedly is true. Volkmann did the same. Some of the best surgery that is being done in Europe to-day is being done by men who served under these masters. Yet the point made in my paper, which I think was missed, was the fact that men go into surgery without any real preparation for it. One of the things I look back to with pleasure in my own work is that I killed dogs before I killed anybody else.

"I still maintain that the general practitioner has no right to do surgery. I saw a man remove a mole from the face of a girl who was dead five months after he cut it out. The man, who, when business is dull, gets a case of appendicitis and says to himself that he might as well cut out the appendix as send the patient to Chicago, may be successful nearly all the time, but once in a while the result of his over-confidence is a tragedy.

"There is no man who is doing both medicine and surgery who can ever become a great surgeon. I saw a case of appendicitis not long ago operated on by a general practitioner. It was only an ordinary case, but it took him four hours to take out the appendix. He was a good doctor, too, but he was itching to do surgical work without being able to do it. Fortunately for him his patient got well, but he objected when the doctor charged him one hundred dollars. That same patient, if he had gone to Chicago, would have willingly paid two, three, or even four hundred dollars for the same operation done by a man with a reputation.

"A man never learns where he belongs. The point

I made in my paper was that the general practitioner should learn enough about surgery and its possible results so as not to make a mistake. When he is qualified to do surgery there is no harm in his doing it, but until he is qualified, it is well for him to go slowly."

# APPENDIX F

## CONSERVATIVE SURGERY AND FEE-SPLITTING

A brief extract was given in Chapter VIII from Dr. Henry S. Luhn's paper on "Conservativism in Surgery," read before the Associations of the Pacific Northwest (Section on Surgery), July, 1909, and published in *Northwest Medicine*, January, 1910. The following extracts are taken from the discussion that followed.

Dr. J. R. Yocom (of Tacoma, Washington):—

"This paper brings before us a great many points of practical interest and many of vital importance. I can only touch upon a few. It seems to me the first essential of conservatism in surgery is the preservation of the patient's life. No operation is justified which does not have that first consideration. The second is to preserve to every organ its greatest functional efficiency possible under the conditions. If you keep these two things in mind, you have the basis of conservatism in surgery. In the case of suspected malignant disease, conservatism consists in removing every particle of that growth that is possible, and still save the patient's life. In the case of traumatic surgery, there has been a wonderful change in this respect in a few years. In our ordinary hospitals fifteen years ago amputations were common; now they are very rare. We are trusting more to Nature. The more cases I see the more I am surprised at the conservative and reparative power of Nature, if given half a chance. In almost every case there is time to amputate after you have first seen what Nature can do. In the case of fractures, my practice is to get a radiograph in every case of injury to bone or joint, even a sprain. After reducing and putting on a dressing, I have another taken immediately to see if the parts remain in satisfactory position. If not, I at once make another attempt to reduce it. If I then find I cannot get the parts into position and keep them there, I cut down and fasten them. I think this is the wise, conservative practice for the patient. I feel more and more confidence in the reparative power of Nature in inflammatory diseases of the pelvic tissues. We do not know that an organ has not some function because it is not performing the one usually ascribed to it. Removing diseased ovaries or tubes is not always a necessary operation. If given a chance Nature will often induce recovery. Conservatism, on the other hand, does not mean procrastination. It is the middle course between procrastination, and too hasty operative procedures just because the patient will lie down on the operating table and let you operate."

Dr. Park Weed Willis (of Seattle, Washington):—

" Conservative in surgery is a relative term, but Doctor Luhn's paper gives its true ring. We must learn all we can about our patients and then do what we think is best for them, fearlessly. The term conservatism has been used frequently with reference to those who have made diagnoses of severe intra-abdominal affections, and then sat still and allowed the patient to die. We have now a beautiful group of neurasthenics walking around with their stomachs connected to various portions of their intestines to testify to the surgery that was not conservative. We must try not to have the next generation carry such testimonials. We do not want to overlook things. When the patient has pains in the abdomen and we cannot determine after very careful examination what is the cause, it is often right to open the abdomen, explaining to the patient that we are doing it for the purpose of finding out what is the trouble, and usually we are rewarded by finding something that our surgery can relieve. As to the question of fee-splitting, I think the essayist is exactly right. If I charge $250 for an operation and give some other man half of it without the knowledge of the patient, I admit that my services are only worth $125, and I am paying some one to bring this case to me. This is wrong. It is right, however, for the family practitioner to be paid, when he comes 100 miles or any other distance, after he has made a diagnosis and done the drudgery, but the patient should know about it. Everything should be open and above board."

Dr. F. J. Fassett (of Seattle, Washington):—

"To return for a moment to conservatism in surgery, there is one field in which I would make an earnest plea. I refer to the radical operations for removal of joints in children. Understand that I put the emphasis on the word children, because in adults the question of economics, the necessity for a quick return of earning power and all that sort of thing have to be considered. It seems to me that the conservative treatment of tuberculosis joints for months and years before they are subjected to radical operation is well justified. A leg with a stiff joint is of a lot more use than a leg that is three or four inches short. It seems to me that along this line conservatism should be the watchword, and that it is especially needed in this particular part of the country."

Dr. Mary K. Mack (of Chicago, Illinois):—

"I see you are most interested in the subject of fee-splitting. I come from Chicago and was there during the hot battle fought upon this question. There was a great deal of bitterness over this question; the newspapers took it up and made much of it; and there were spies sent around to interview the doctors, pretending that they needed surgical assistance. It finally brought on threatened lawsuits and bitter fights in the State Medical Society. It was found that the majority of our surgeons were splitting fees; names were brought and there were many scandals stirred up. The result was that the same old game is still carried on in the same old way. There is no difference whatever. My husband is a surgeon at St. Ann's Hospital. We have many cases coming in and we feel that the doctor who sends them deserves money, but it must be done in an upright and honorable manner. We sometimes have written contracts, sometimes verbal, and often it is left to the country doctor if we know him well. I think after all your oratory is spent and articles for your journals have been written you will end here in just the way that we did in Chicago. You will go on fee-splitting the same old way."

Doctor Luhn, in his closing remarks, replied (in part) as follows:—

"As was very aptly stated by Doctor Mack, of Chicago, we shall probably go on in the same old way. She states that the fees, according to the routine of St. Ann's Hospital, are left largely to the country doctor or the doctor referring the case. That does not lessen the fact that those who thus leave the matter are certainly outraging their patients. The matter of fee-splitting I denounced in my paper as an outrage. It was a matter of conclusion, coming under the heading of the treatment we owe our patients and ourselves. Doctor Yocom's remarks as to inflammations in the pelvis agree with my experience. It is bad surgery to enter a pelvis that is the seat of acute inflammation. Later the patient recovers from local inflammation. Nature comes to her assistance, and we may have the pleasure of seeing the patient in the vigor of health and bearing children when, by interference at the time of inflammation, we might jeopardize the patient's life."

On the question of fee-splitting let me add the following editorial from the *American Practitioner and News* of Louisville, Kentucky, for May, 1910:—

" It has been said that it is the heaven-born privilege of an editor to talk about reform. Under this dispensation we call attention to the clandestine yet notorious bargaining carried on in the profession by those who have not the countenance to profess openly what they actually practise.

" Splitting fees, the paying or receiving commissions for patients referred, is a reprehensible traffic that unquestionably victimizes unsuspecting patients, discredits trusted participants and degrades an honorable profession.

" That this brokerage in patients is carried on is beyond denial—to what extent is for apparent reasons difficult to determine; however, the exposure of the decoy letter correspondence in the *Chicago Daily Tribune* some years ago gives convincing indication of its prevalence. These letters, framed by a Chicago specialist for the purpose of collating the replies and reporting them to a local society, were sent from Odell, Illinois, to one hundred Chicago surgeons and physicians and read as follows:—

" ' My dear Doctor: I have a case under my charge which requires attention along your line of work. I am not quite sure of my diagnosis, but will leave the whole matter to you. The people have heard of you favorably and are inclined to go to you for treatment. As they are wealthy, they ought to pay a good fee for the service. Now, doctor, you understand that I am a young man just starting a practice, and in small towns we cannot make any distinction between the rich and poor in matters of charges. I have only received my regular visiting fee in this case. I understand, however, that it is customary for physicians to pay a commission of 25 per cent. upon all referred work, and I shall deem it a favor if you can take care of me in this matter.

" 'Kindly let me hear from you by return mail, as I am anxious to bring the case to you at once if satisfactory arrangements can be made.

" 'Yours truly,.........'

" Of the forty-four replies eighteen consented to the arrangement—a percentage that staggers belief; unfortunately (?) the entire correspondence fell into the hands of the lay press, which published the letters of those accepting—and lo! the names of the prominent were there.

" But this infectious evil that thrives under cover is neither sporadic in Chicago nor endemic in this country. We learn that the eminent Pean was a pillar in this subterranean institution of commercial surgery in France; that Louis XIV. was on one occasion phlebotomized by an ambitious young surgeon, recommended by the King's Physician, and when it was discovered that the latter had profited by the division of the fee paid the operator, the Council of State unanimously voted his death for 'having made traffic of royal blood.' It has recently come to light that representative members of the German profession have been bartering patients. In Belgium the Council of Physicians have had the matter before them for discussion and have given this buying and selling of patients the name of dichotomy.—But it does not matter by what technical name it is disguised, or how cunningly it is carried on or how skilfully concealed from the patient, it is the same everywhere—graft, pure and simple.

" Surely the general practitioner should be paid for the services he has rendered, but why commission the specialist as his collector in secret? If any compact is made at all, it should be made openly with the previous consent of the patient. The family physician has no right to receive compensation save for professional services rendered by him and it is unconscionable to profit secretly because his patients need more expert service than he can give.

"Nothing is calculated more speedily to bring the honorable profession to greater disrepute than the laity's knowledge of this illicit practice. The exaction of money for one purpose and its surreptitious diversion to another is not a mere dishonesty but a breach of confidential relation so sacred as to make the suppression of the truth an act of disloyalty.

"'No man can serve two masters'—he cannot serve both his Divine Art and Mammon. The surgeon who will split fees will increase the size of his bill to keep himself harmless from loss, and the family physician from self interest will be tempted to overlook the overcharge, and thus the *uberrima fides* existing from time immemorial between patient and doctor will be forever destroyed.

"But how to eradicate this underhand 'dickering' is the problem. Medical societies can do no more than stamp their disapproval upon it; they can no more control it than they can the abortion evil, for the dark secrecy of these transactions prevents detecting who's who. No medical legislation can enforce honesty,—for in the last analysis the lack of honest candor is the gist of the wrong.

"The suggestion that medical colleges should teach students what is ethically right, raises the question whether all professions are like Cæsar's wife—above suspicion—and reminds one of Satan rebuking Sin.

"Very recently the following resolution was passed by the Indiana University School of Medicine:

"'*Resolved*, that any member of the faculty or teaching staff of the Indiana University School of Medicine, who shall be shown to be guilty, either directly or indirectly, of fee-splitting, making an offer to split a fee, paying a commission for patients referred, or any violation of Article 6, Section 4, of the Principles of Medical Ethics of the A. M. A., shall be considered as having so impaired his usefulness as a member of the faculty or teaching staff of the School of Medicine by such unethical example to students, as to make his further connection with the faculty undesirable.'

"The adoption of this resolution by all medical colleges will be a stride in the right direction, and will afford an unmistakable ethical precept to the students of medicine."

# APPENDIX G

## "GRAFT" AND INCOMPETENCE IN SURGERY

The following extracts are from the discussion of Dr. A. H. Cordier's paper on "Some Elements of Success in Surgery." This paper, from which a brief excerpt is given in Chapter VIII, was read before the Thirty-fifth Annual Meeting of the Mississippi Valley Medical Association, October, 1909, and published in the *Lancet-Clinic*, January 15, 1910.

Dr. J. Henry Carstens (of Detroit, Michigan):—

"A short time ago I prepared a paper on the embryo surgeon in which I expressed ideas similar to those that have been set forth to-day. I contend that nobody has a right to practise surgery, and especially abdominal surgery, unless he has been an assistant to a surgeon for at least one year, to a surgeon who has had a large hospital experience, who has done hundreds and hundreds of operations, witnessed by this assistant, and then the assistant will have seen the troubles and trials and complications that are met with in surgical work, so that he may have some kind of an idea of what he will be confronted with when he undertakes to do surgical work.

"When a practitioner goes to a post-graduate school and sees the eminent professor make a cut, puncture a cyst, pull it out and tie it off, putting in a few stitches and closing the wound, and doing all in about four minutes and a half, a great impression is made on him. He probably thinks that he can do the same, but finds that he cannot. The line must be more strongly drawn with regard to surgeons and those who are training themselves to become surgeons. Of course, educated people know this already. They find out who the good surgeon is. The general practitioner ought to know who is the good surgeon, and he ought not to trust anybody to do an operation. Each practitioner of medicine has a right to perform operations, and we as surgeons are willing to teach them and we have taught them by the hundreds, but some practitioners will not take the time to master surgical principles and surgical technique. They say, 'Well, I make mistakes.' Yes, and you make a lot of mistakes. But, because I make mistakes, there is no reason why you should do so in these modern days. We as surgeons blazed a new path and made a new kind of surgery, because we did not know. We made mistakes, but that is no reason why everybody else should do the same thing. We learn from our mistakes, and by these various mistakes we finally have simplified our surgical work so that it is comparatively easy now as compared with former days. But even in spite of that, there is a great deal of difficulty attending surgical operations, and practitioners must learn to master these difficulties. They have no business to go right out of a medical college and say they are surgeons. They should go into a hospital where they can see surgical work done, and serve a reasonable time under the guidance of good surgeons. I agree with Doctor Cordier in everything he said."

Dr. C. M. McGannon (of Nashville, Tennessee):—

"We all agree, I believe, that the enthusiasm of youth leads many a man, who has recently graduated, to rush into the fields of large surgery—fields he would do well to keep out of until he is better trained. But how are we to stop it? I thought Doctor Cordier was going to point out some way by which these things which make against success can be remedied. Is it the duty of this Association, or any other society, to adopt such measures as will prevent these enthusiastic young men from rush-ing into a field that they at least imagine they can fill? It is true that many of us have had the opportunity of seeing the disasters which follow such work, but how are we to remedy it? I have heard it said, again and again, in medical societies by young men: 'If we do not do these operations, how are we to learn surgery?' If a man has not the money nor the time to go into the large fields suggested by Doctor Carstens, where he may get the experience and education to be obtained from men who are doing work like that which Doctor Carstens is doing, then he is not competent to do surgery, and any surgical work he may undertake, with his little experience and skill, may terminate disastrously. This is a condition which we would like to remedy, but I do not see how we are to apply the remedy.

"Doctor Cordier did not say that young men of experience were operating upon inoperable cases because of a fee or because of over-enthusiasm; yet I think from his remarks one might possibly be misled into believing or thinking that was implied. Now, I am unwilling to think that any reputable man in the medical profession, to say nothing of men of great experience, would operate upon any patient for the purpose of getting a morbid specimen, or for the purpose of getting a fee, and especially if he knew the patient was not to derive benefit from the surgical procedure; as, for instance, a case of cancer of the breast, or one of cancer of the uterus, in which the disease is so pronounced that it would be extremely doubtful if any surgical procedure undertaken for the removal of the disease would not be fraught with disaster, and certainly would not be followed by success. That would be a case of operating on an inoperable case, with the matter clearly in the mind of the surgeon before he began, so that he would be open to the charge of operating for the purpose of getting a morbid specimen or for getting a fee. I should be extremely sorry to think that any man in the medical profession, who has any opportunity to operate, who enjoys the confidence of patients to the extent that they will permit him to operate on them, or who enjoys the confidence of his fellow-practitioners so that they will send patients to him for operation, would be guilty of anything of that kind, and I certainly cannot and am not willing to concede that point."

Dr. Channing W. Barrett (of Chicago, Illinois):—

"I think that the question as to whether a man would operate on any case for a fee is settled by the question of what is done in cases of abortion. Why is it that in any community an individual can easily have an abortion produced, and sometimes by men who are just as good as any one of us? I do not suppose there is a town in the whole United States where a woman cannot get an abortion produced on her if she pays the price.

"Surgery is coming to occupy a large place in the world, and it is our business as practitioners to see that surgical work is made just as successful as possible. The only question is, what constitutes success in surgical work? Our greatest surgical work only comes when every patient that needs operation and is operated on will be benefited. Every patient who does not need an operation should be eliminated from operative work. We find people having operations performed on them who do not need them. We find many people needing operations who do not have them, and we find people who need operations are having them done by men who are not at all trained for that work. Now, we want more training, and if these men have not got the time to train themselves for this work, they should not be doing it. The mere excuse that they have not the time to learn a thing is no excuse for doing work without learning how to do it. The time has gone by when any man should plunge into surgical work and kill patients, without learning to do surgery properly. The opportunities for learning to do surgery are too great, and they are too cheap, and, as Doctor Carstens has said, those who are doing surgical work are willing to train them. Some men may think that it is not necessary to serve an apprenticeship in order to learn how to guide a boat in and out of the harbors of New York, Boston and Chicago; but such men have to go through that apprenticeship to do it, and they do it, and they do not learn it by serving as stationary engineers. They have to begin at the bottom and learn how to do it. They learn the landmarks before they can do it, and why should not men who contemplate doing surgical work be willing to go through similar training?

"Something has been said against the post-graduate schools. The trouble is not with these schools. Men should take time. If a man is going to do surgery, he ought to spend several days in seeing one surgeon operate, or one month, or devote as much time as he possibly can to the work, and in seeing the work of other surgeons. But because he has seen the work of one surgeon for a day or two, does not mean that he should undertake to do similar surgical work.

"Great trouble comes from men putting their own interests first instead of stopping to think of the interest of others—their patients. We should always consider, first and foremost, what is the best interest of the patient in this or that case. What would I do if this patient were my mother, my brother, my sister or my son? The question oftentimes appeals to one, What do I want to do? What shall I get out of this if I operate? What shall I get out of it if I do not send the patient to a surgeon? These things influence 60 per cent. of the surgical work done at the present time."

Doctor Cordier (in conclusion):—

"There is very little more to say except that several times in my paper I apologized for the situation or state of affairs, such as my good friend of Nashville, Doctor McGannon, referred to. I do not know what we are going to do about it. However, it does not do any harm to discuss this subject, and as our proceedings are being reported, this discussion may drift into the hands of someone and thereby do good.

"In regard to the mortality rate, we have to-day the greatest surgical operators that the world has ever known, and no one approaches the percentage of recoveries of our operators to-day. But when we go back and think of the conditions under which Dudley, McDowell and others did their work, without anæsthesia, without skilled assistance, without asepsis, and without hospitals, and realize the two hundred and six stone operations done by Dudley, with a mortality of only four, there are not many surgeons who are beating that record to-day. This man did not select his cases. His cases came in from all over the South to have stones removed from their bladders. Some of them were old men, decrepit, broken-down individuals, and yet this man, under unfavorable circumstances and conditions, operated on two hundred and six, with a mortality of four. Let us take McDowell's work of thirteen ovariotomies, with nine recoveries, a percentage of nearly 75. Let us take the operations done to-day all over this country and I question very much as to whether we are getting 75 per cent. of recoveries following ovariotomies in the class of cases dealt with by McDowell. They were not operated upon under the most favorable conditions; they had leakage; they had adhesions and peritonitis following tapping and other unsurgical procedures, and yet McDowell saved nine out of thirteen cases.

"My remarks were not intended for good and efficient surgeons, but for the other fellow, the man who is untrained for this work. That is the fellow I am after.

"In regard to operating for the purpose of getting a fee or obtaining a specimen, it is only necessary for you to visit certain localities where you will see cases of Hodgkin's disease operated upon right along. Glands are removed from the neck when the groin is filled with them. They are in the axilla, they are all over the body, and the operator says to the class, 'I will take out a few of these and examine them for pathologic purposes.' Now, I do not want to throw any stumbling-blocks in the way of progress. A patient, for example, comes in with an extensive cancer of the neck, and yet the surgeon wants to do Grant's operation, or some other operation, in order to demonstrate to some of his surgical friends the operation. But he has charged for that operation. He has subjected that patient to a procedure that has a primary mortality with no cures, and such operations prevent other people from being operated upon for cancer in time to be saved. This is the class of cases I have referred to. My sympathy along this line is the same as that of Doctor McGannon, but I was dealing with facts and not with sentiment when I read this paper."

# APPENDIX H

## "THE VENEREAL PERIL"

The following is from the introduction to a pamphlet entitled " The Venereal Peril," by Dr. William L. Holt, edited by Dr. William J. Robinson and copyrighted and published by " The Altrurians " (New York, 12 Mount Morris Park West, 1909—Price 25 cents). This pamphlet and " The Social Evil, Its Cause and Cure," by the same author, deserve the widest circulation.

" A generation ago, when a young man went to his family physician with his first gonorrhœa, he was comforted with the assurance that after all it was no more serious than a bad cold. Now we know that syphilis and gonorrhœa are as great a scourge to society as tuberculosis and alcoholism, and that gonorrhœa is responsible for more injury than syphilis, because it is six times as common and has quite as serious results in many cases. It is the chief cause of sterility and impotence; it makes thousands of women lifelong invalids from peritonitis; and it destroys the eyesight of thousands of infants by infection from the mother during birth.

" Most people have no adequate conception of the terrible prevalence of the venereal diseases, and hence do not realize that they are a menace to the national health quite equal to if not greater than tuberculosis. Unfortunately, the total number of cases of venereal disease in any state or city is not known, because physicians are not compelled to report their cases. We can only estimate. Such estimates of course vary greatly; I will give only a few by the best known authorities in America and Europe. Dr. Prince A. Morrow, the president of the American Society of Sanitary and Moral Prophylaxis, says: 'Probably not less than 450,000 cases of gonorrhœa and syphilis occur every year in the United States among young men. Hospital statistics seem to indicate that 20 per cent. of our young men contract venereal diseases before their twenty-first year, 60 per cent. before their twenty-fifth, and 80 per cent. by their thirtieth.' Another well-known American specialist, Dr. E. H. Grandin, estimates that 60 per cent. of all men on the average have gonorrhœa in an acute or latent stage (i.e., not cured). Dr. William Erb, of Germany, declares that some authorities have exaggerated the frequency of gonorrhœa among men. He carefully questioned two thousand men in his own private practice, which is chiefly among the upper and middle classes, and found that of these 2,000 men, all of whom were over 25 years of age, only 971, or 48.5 per cent. had had gonorrhœa. This estimate is indeed optimistic when compared with that of Ricord, who declared that in Paris 80 per cent. of the men had the disease; but even if so, it is very serious. In the same series of men Erb found that 18.2 per cent. had had syphilis. A special committee appointed to study the social evil and its results in New York in 1903 estimated that there were probably as many as 200,000 syphilitics in that city.

" The fact that venereal diseases find many more victims in America than does tuberculosis is clearly shown by the records of the out-patient department of the Massachusetts General Hospital. During the year 1904 nearly a thousand (983) patients were treated for venereal diseases, while only 430 were treated for all forms of tuberculosis. And we must not forget that a great many men, particularly of the uneducated working class which makes the chief use of hospitals, when afflicted with a venereal disease, avoid the publicity of a hospital and go to a private doctor or to one of those human vultures, the sexual quacks.

" Hereditary syphilis alone causes a large number of deaths in America every year. Here again we can only estimate. If 20,000 children die in France yearly, as is reported, we must estimate that in America with twice the population the number is probably much greater, from thirty to forty thousand. If only one out of ten of the 200,000 syphilitics estimated in New York begot or bore a syphilitic child during the year, there would be 20,000 tainted infants brought into the world, and over half that number would die in infancy or early childhood. For the mortality of hereditary syphilis is notoriously high, though it has been considerably reduced in recent years by better methods of treatment. It is said by some authors to have been even 80 and 90 per cent. in certain places in the past. The statistics of the Foundling Asylum in Moscow for ten years showed that of 2,038 syphilitic infants the mortality was over 70 per cent. And it is well known to American child-specialists that syphilitic foundlings in asylums can rarely be raised unless they can be breast-fed, which is seldom the case, because the infant would infect a non-syphilitic wet nurse and so cannot be given to one. But it is probably better for society that such tainted infants should die, for they usually make weak, degenerate men and women, who, if not cured by thorough treatment, may bear children with syphilitic heredity, thus transmitting the loathsome disease even to the third generation. This interesting point will be treated in detail under its proper heading.

" In this general statement of account against the venereal diseases as agents in race suicide and degeneration, we must remember that nearly half, or 42 per cent., of all spontaneous non-criminal abortions are caused by syphilis.

" What has been the attitude of ' the best members of society ' hitherto toward this great social evil and menace? Indifference, suicidal indifference! The only excuse and explanation of this culpable indifference has been the complete ignorance and misunderstanding of these diseases, especially in their moral aspect, by the good, intelligent part of the community, including the women. The prevailing orthodox belief, at least among the religious, was substantially this: 'It is only vicious, licentious, depraved people who have these diseases. They are God's punishment for their sins, and it would be an impious meddling with the divine will and justice to try to protect such people from the consequences of their sins.'

"It is necessary to teach these people that the non-moral laws of nature affect the innocent exactly the same as the guilty; that as many more innocent women and children suffer from venereal disease as guilty men. Doctor Morrow, who has made a special study of this point, declares that venereal disease is actually commoner among virtuous wives than among prostitutes. He gives a satisfactory explanation for this, which need not be given here. He thinks that fully 8 per cent. of all the wives in the United States have gonorrhœa, contracted of course in the great majority of cases from their husbands. This would mean that over one million American wives are suffering from this loathsome disease, which almost surely blasts the life of every wife and mother whom it afflicts.

"The following statements by specialists of wide experience confirm Doctor Morrow's. Gruber, of Germany, says: 'Thousands or hundreds of thousands of innocent wives have gonorrhœa.' Doctor Noeggerath, of New York, declared that fully 80 per cent. of all men who married in that city carried the germs of gonorrhœa in a latent if not in an active stage and hence were liable to infect their wives. This estimate is probably greatly exaggerated. Let us hope that Doctor Erb's careful statistics of 49 per cent. of all men above 25 years infected is also true in New York. It is surely bad enough. On the point of the frequency with which gonorrhœal infection of the wife from the husband occurs, there is considerable disagreement. While Doctor Erb is extremely optimistic and found that only 4 per cent. of the wives of 400 men who had had gonorrhœa had contracted it, others believe that of every hundred women who marry men formerly infected with the gonococcus (germ of gonorrhœa), fully 90 per cent. contract some form of the disease. Zweifel and Saenger, of Germany, find that 18 per cent. of all women have gonorrhœa. The explanation of these wide variations lies in the extreme difficulty of diagnosis of gonorrhœa in women, which often amounts to an impossibility. We are not here concerned whether the small or the larger figures are nearer the truth; we are concerned only with the great fact that a great many innocent women and children are suffering from gonorrhœa and syphilis, and hence sufferers from venereal disease must not be scorned as outcasts, but treated as are consumptives with the sympathy and humanity which they deserve.

"How can this terrible condition of affairs be changed? How can venereal disease be prevented? There has been a great change in the attitude of physicians, intelligent clergymen, and all humanitarians toward this problem during the last few years. The old attitude was based on ignorance and the Calvinistic doctrine of predestination; it was pessimistic, just like the old attitude toward consumption. The new attitude is based on scientific investigation and knowledge of the facts, and ignores theological dogmas of divine punishment; instead of a barren superstitious faith in a cruel, unjust God, it substitutes a well-grounded fruitful faith in the laws of Nature, in Science, Reason, Human Nature and Evolution. Progressive American physicians now believe that the venereal diseases, like consumption, have definite ascertained causes in social, moral and economic conditions, and are essentially preventable by improving these morbid conditions. We believe that in the course of time they can and will be as greatly reduced in frequency as yellow fever has been in Cuba and smallpox in Europe. We hope some day in the far future they will become extinct."

# APPENDIX I

## CRIMINAL ABORTION

Several extracts were given in Chapter XI from the paper—"Criminal Abortion in its Broadest Sense"—read by Dr. Walter B. Dorsett before the Annual Session, held in Chicago, 1908, of the American Medical Association (Section on Obstetrics and Diseases of Women). The lengthy and animated discussion which followed showed that many of the members of the Association are becoming thoroughly aroused as to the magnitude of this evil. The following comments, as reported in the *Journal* of the Association of September 19, 1908, are a part only of the discussion, but will serve to show the feeling of those present.

Dr. W. H. Wathen (of Louisville):—

"No subject could be brought before this Section which is of more vital importance in a moral, and I might say in a pathological sense, than this. We who are doing abdominal and pelvic surgery know how frequently we are compelled to operate because of the induction of abortion. In a moral sense it is offensive to every honest doctor and to every honest citizen. This offence is not any more an offence on the part of the woman on whom the abortion is committed, be she married or single, than it is on the part of the person who commits it. I believe that in most of the cases in which I operate for pelvic trouble resulting from induced abortion, the abortion has been induced on the advice of a physician or done by a physician, and I have seen many cases in which abortions have been induced by members of reputable medical colleges. The matter is disguised by the fact that a woman six weeks or two months pregnant is often taken to a hospital for the purpose of curettage. Her uterus is curetted and the product of conception removed. In order to secure legislation there must be impressed on the profession the belief that, if there is any moral offence in destroying the life of an unborn child, the moral offence is just as bad four weeks after conception as if the child were killed at eight months. From the moment of conception the child is a spiritual being. Let us all join in our efforts to educate the people, the women and men, of this country concerning the immorality of having abortions produced at any time and let us join in efforts to have laws enacted that will make it a criminal offence, punishable by such penalties as the state sees fit to inflict, death or a sentence to the penitentiary, for any man producing an abortion."

Dr. J. H. Carstens (of Detroit):—

" Laws have been enacted all over the country concerning murder, but still people commit murder. We have laws in some states concerning abortions, but people produce abortions just the same. With the peculiar development of our civilization, with the rapid bringing up by a very rapid process of evolution of people from a lower stratum of society to a higher, people have not grown morally as fast as they have otherwise. They think that there is nothing earnest in the world, that it is just made for them and for their pleasure, and everything that interferes with that pleasure they object to and try to do away with. This question of abortion involves the lack of moral responsibility and the superficial education of our girls all over the country. They are not impressed with the true import of life and the responsibilities of married women. They are not taught that a woman does not exist for social pleasure alone, or that she can take her place in society and have pleasure, but that she should still remember her moral responsibility and that it is good and noble and great to be a mother. If we can impress this idea on the minds of the people we can do something to prevent the committing of abortion. If we do not we shall never accomplish much by law. I believe that it is the duty of the medical profession to emphasize this view of the matter, to develop this view of moral responsibility, to try to induce women to have a love for children."

Dr. R. W. Holmes (of Chicago):—

"I have had the misfortune for three years to be a sort of mentor on criminal abortion work in Chicago. During this period I have presided over a committee of the Chicago Medical Society to investigate, and to attempt to eradicate the evil; I have come to the conclusion that the public does not want, the profession does not want, the women in particular do not want, any aggressive campaign against the crime of abortion. I have secured evidence. I have asked different physicians, who either had direct knowledge of crime against the prisoner before the bar or who could testify as to her general reputation, to come and testify. They promised to come, but when the time for trial is at hand no one appears. On the other hand, so-called reputable members of our Chicago Medical Society regularly appear in court to support the testimony of some notorious abortionist. A Chicago attorney has told me that it is not possible to get twelve men together without at least one of them being personally responsible for the downfall of a girl, or at least interested in getting her out of her difficulty. I am convinced that legislation is not needed, at least in Illinois. We have as good a law as perhaps can be made. It is the enforcement of law that is needed. What can we expect when a member of our legislature is backing financially and politically one of the most notorious abortion hospitals in Chicago? It is necessary to go back and educate the boy and girl concerning the meaning of sexual life. The fact should be taught that life begins with conception and not with quickening. Then perhaps in the coming centuries we shall have reached a time when there will not be abortions. I believe that half of the midwives of Chicago get their support from criminal abortion work, as I know definitely a quarter do. One midwife took out a license to help out the family exchequer. For one week she had a sign up; then the husband said that they could not run the risk of the police coming down on them. In that one week there were ten applicants for criminal abortion and not one for a confinement. I do not think that it is a good thing for a woman to be held criminally. Morally she is a criminal. If she is legally a criminal you could not get any evidence of it. I have evidence of this every day. I have repeatedly taken ante-mortem statements, with the express provision that if the woman recovers nothing shall be done, that only if she dies shall the person be prosecuted. I have positive evidence that prominent men in Chicago—and Chicago is not different from other cities—will commit abortion. What can one do? In a certain county society complaints were lodged with the censors concerning three physicians known by reputation and deed to be professional abortionists, and the censors refused to take action.

"Fundamentally it is a matter of education which should be begun in the medical school. Until three years ago the school with which I am connected did not have any systematic instruction on criminal abortion. It had a little lecture by a lawyer who did not present the actual facts. Every medical school should have a course on that subject. There should be impressed upon the men before they take up their work the dangers to the woman, to themselves and the moral responsibility assumed in the matter of abortion. If also the boy and girl in school are taught something of this, they will grow up with moral stamina not easily overcome. They will know facts and will live accordingly. Many now make themselves believe that there is no life until the movements are felt. When the false teaching in this respect is put aside, good will be accomplished."

Prof. August Martin (of Berlin, Germany):—

"I believe that in Germany and everywhere all agree in condemning criminal abortion. It is forbidden by law; it is forbidden by the professional code of ethics. Laws have been issued in numerous communities to try to suppress criminal abortion, but I do not know of any which have had success. Our laws themselves place great difficulties in the way of legal action by forbidding us to speak about professional secrets. When we are called in a case of criminal abortion we are not allowed to give evidence unless the parties interested in the case give us permission, and frequently this permission can not be given, as the poor patient is dead. But when a good chance is offered to give evidence, then, indeed, in every case our courts condemn criminal abortion with the utmost severity. Joint efforts in condemning criminal abortion as on this occasion by and by will contribute to restrain the evil among professional men."

Dr. R. S. Yarros (of Chicago):—

"To formulate laws and have them enacted is comparatively easy. To enforce a law is an entirely different thing. You cannot enforce laws, as some of the speakers have already said, with which the public has little sympathy. Even if we could enforce anti-abortion laws the problem would not be solved. I find that among the poor there is very little danger of race suicide. They have not learned yet to practise prevention, nor do they frequently resort to abortion. Their great love for their children is a factor in the situation, and in this respect the higher classes might well take a lesson from them. Unfortunately, they often have too many children, and one is inclined to preach moderation and restraint without regard to race suicide. The rich, on the other hand, go to the other extreme. They frequently have no better excuse than that it is inconvenient to have a child at this or that particular time. They have no difficulty in procuring professional services to help them out of their difficulty. As for the unmarried victims, it is the disgrace that society has imposed on them, as well as the economic inconvenience, that drives them to commit abortion. It seems to me, therefore, that the most stringent laws and their enforcement would not remedy the evil. The proper education of the public on the subject is the most important duty before us. The blame should not always be placed on the woman. It should be realized that there are two parties. I do not want the woman not to take her share of the blame, but I want the man to take his. We all know that men frequently encourage the woman to have an abortion produced, and are willing to pay any amount of money for such services. In this city there has been considerable education carried on among women of the dangers of infection following abortion and the sex problem in general. The work has met with sympathy and enthusiasm on the part of the women. We hope that the same kind of work will be carried on among the men with the same success."

Dr. Walter B. Dorsett (in conclusion):—

"The city of St. Louis has not been remiss in her duty in this regard. A paper was read recently in one of our meetings by Dr. John Grant of St. Louis on the subject of criminal abortion. The meeting was attended by many of the laity and clergy. One clergyman, who was much interested, promised to preach a sermon before his congregation, but his board advised against it. It seems to me from this that things have come to a bad pass. In order, however, to show you what has been done and what can be done, not only in the enactment of laws but in the enforcement of them, I will quote from a letter which I received from Dr. Wheeler Bond, the health commissioner of St. Louis, in response to an inquiry I made of him. He said that when he accepted the position of health commissioner there were licensed physicians and midwives who concealed illegitimate under the pretence of legitimate practice, and charlatans who without any authority proclaimed themselves doctors and waxed fat on abortions. There were also lying-in institutions which advertised that they accepted only legitimate confinement cases, but which gave out the understanding that all cases would be received. The St. Louis Medical Society found on investigation no less than three of these abortion shops in which young women who came there to await their confinement were kept as prostitutes to pay for their confinement. During the following year many of them were put out of business. By the enforcement of the federal laws also we have in St. Louis dealt with a number of the advertising quacks. We must have good laws before we can expect results, and therefore I believe that we ought to take some action on the question."

# APPENDIX J

## BERNARD SHAW ON THE MEDICAL PROFESSION AND THE COMPETITIVE SYSTEM

At a meeting of the Medico-Legal Society held in London last year, Mr. Bernard Shaw criticised the doctor and his methods from the socialist's standpoint, and the fact that his address was published in full in the *Lancet* shows how seriously our British cousins regard the approaching crisis in the medical profession. The following is taken from the abridged report in the *Journal of the American Medical Association*, April 17, 1909, but even this, unfortunately, had to be again condensed:

"Mr. Shaw said that he belonged to a generation which began life by hoping more from science than perhaps any generation ever hoped before and possibly might ever hope again. The doctor of the present day had been practically driven into the position of a private tradesman. Nowadays almost all the old professional pretensions and delicacies had been dropped. A doctor gave an opinion and the patient asked him what he owed as boldly as one would a shopkeeper in the street. He could remember the time when one did not do that. This position had never really been recognized, but it must be realized and admitted that as competition in ordinary trade and business had been shown by elaborate theoretic demonstration to be the best thing in the world, medical affairs could form no exception. The idea of a doctor being a tradesman was abhorrent to any thoughtful person, and therefore considerable restrictions were imposed. Advertising in the ordinary way was a thing forbidden. When a professional man had become so successful that he wanted to 'weed out' his poorer patients and keep his richer ones, he raised his prices, and also gave up the power forever of recovering his fees in the county court, which was what the ordinary practitioner very largely had to do at the present time. There being no systematic organization of his profession, naturally the doctor was forced by circumstances—however repugnant to his feelings—to go into the commerce of healing and to become a professional ' medicine man '—a professional healer—who sold ' cures ' because that was what the public went to him for. The great mass of the medical profession had to get what they could and be very glad to get it.

" The attitude of socialism toward the poor man was that the poor man was necessarily a bad and dangerous man. The attitude of the man who was not a socialist toward poverty was that poverty was a very good thing, that it developed character, and in other particulars had a beneficial effect. But the really sensible man always regarded poverty as a bad thing and held that the poor man was always dangerous, and that the doctor was a specially dangerous man when poor. The doctor's poverty at the present time drove him necessarily into doing things which he would not do if he were independent. He was—like most men—as honest as he could afford to be. The carrying out of all the various hygienic measures which doctors knew to be scientifically necessary would be enormously expensive, and the slightest attempt to force them on patients or to let patients know that the absence of them was dangerous would cost a man his practice and his livelihood. What the great mass of patients really needed, at the present time, was not medicine or operations, but money, better food, and better clothes—and more frequent changes of the latter—and well-ventilated and well-drained houses; but what was the use of prescribing those things to unfortunate people who could hardly keep body and soul together? The patient, not being able to afford scientific treatment, demanded cheaper 'cures,' and the result was that the doctor had to gratify him in a way. The doctor depended on his patient for his livelihood, and therefore was dependent on the patient's ignorance, and finally had to flatter all his worst delusions. A doctor was like a servant trained in one of those big charitable institutions that train servants. He obtained his training at the hospitals, when he had nurses and antiseptics, and so on. He was placed in a building wonderfully and beautifully built, with no right angles, but beautifully rounded corners; and then, after all that (exactly like the servant), he was suddenly pitched into a poor district and had to go through life in surgically dirty clothes and do his work in surgically dirty rooms with surgically dirty people who could not afford medicines or anything, and he got a sort of skill at it. Mr. Shaw contrasted the position of the ordinary doctor and that of the medical officer of health, with his independent salary, and his position irrevocable by the local authorities. The medical officer of health was in an ideal position—the socialist position—the position in which socialism wanted to place all doctors.

"A doctor at the present time was expected to do everything connected with his profession. That did not apply in the other professions. The judge sentenced a man to be hanged, but he was not expected to be the hangman. If he were the doctor he would be expected to act as hangman. There were men of extraordinary dexterity as operators whose whole time should be reserved for the most difficult cases, but instead one found those men poulticing whitlows and doing trumpery dressings that should be done by the nurse. They were found prescribing for ladies who had the same reason for asking for tonics as the charwoman had for asking for gin. In order to get the maximum of hygienic influence and the greatest economy in using the skill of the profession, it was necessary to get medical men organized, so that different grades did different work, and that the mere routine should not be left for the best men to do. Such organization was altogether impossible while private practice was the rule. It could be done only if the profession was organized publicly by the state. A private practitioner could not get ahead of the prejudices of his patient, and one of the things from which the doctor ought to be released was that abject dependence on his patient. Public opinion would be the final arbiter all along, but it was important to get every doctor in favor of educating the public scientifically, whereas now the doctor had the very greatest interest in preventing the patient knowing anything at all. The medical profession must really be socialized, for the reason that medical men were finding themselves more and more driven to claim powers over the liberty of the ordinary man which could not possibly be entrusted to any private body whatever. If these things were going to be done and if scientific opinion was going to compel people on such a scale, then there must be democratic control. It would be intolerable tyranny unless it were controlled by the people. They were coming more and more to the point of giving the doctor the power of saying what was to be done with the child and denying that power to the parent. It was a curious step and one that would be fought energetically. It was impossible to leave the body in the hands of a private practitioner.

" 'You must make up your minds,' concluded Mr. Shaw, 'that the inevitable result is the socialism of the medical profession. As to what will happen when you have the doctor in the responsible, dignified and independent position of a public servant, instead of a private tradesman—as to what will happen to the surviving private practitioner I do not know. If a doctor finds himself in the position of depending on the caprice and ignorance of patients he will always, under socialism, be able to get an independent position in the public service, and if he elects to continue in private practice he will not be compelled to make the humiliating concessions and the treacheries to science that he now has to do. Having the alternative of public service, he will be in as independent a position as if he were a public servant, and, on the other hand, the patient will always have the choice of getting public attendance, and so he, having the alternative, will be as well off with the private doctor as he will be with the public doctor.' "

# APPENDIX K

## A PLEA FOR HOSPITAL REORGANIZATION

The following article, which is copied in its entirety, is by Dr. Graham Lusk (of New York) and appeared in the *Journal of the American Medical Association* for April 30, 1910. Doctor Lusk has for some time been an earnest advocate of the reforms he so convincingly sets forth in this paper.

" Let us agree that we are all truly desirous of promoting scientific medicine. How is its development to be accomplished? It seems that the following propositions are axiomatic if the science of medicine is to be truly fostered.

" 1. The scientific physician or surgeon must have a continuous service in one hospital and in one only.

" 2. Appointment to the position of visiting physician or surgeon to a great hospital should be dependent on a reputation for accomplished work.

" 3. In the hospital, preferably on the other side of the hall opposite the hospital wards, there should be laboratories for careful scientific investigation and for carrying forward research regarding the causation and cure of disease.

" 4. There should be some endowment to pay for brains.

" All have heard of these propositions, but how much serious concentrated attention has ever been given to them? To what extent has the system been permitted to drift along in the old ways of the fathers? The development of a New York lawyer is not dependent upon the development of French, German, or Chinese law, but it is dependent on purely local conditions as they exist in this country. For example, the legal position of the railways in Berlin is quite different from that of the railways in Washington. Typhoid fever in Berlin, however, is the same typhoid as occurs in Washington. Physicians can learn much if they will adopt a world viewpoint. A progressive New Yorker should fight to destroy the local conditions which fetter his progress and suck his life's blood.

"The continuous service is absolutely essential to progress. The wards must be the glory and the pride of the master-mind in charge. They must be a part of his reputation, a part of his joy of living. The head nurse should not be the principal person who is in continuous control. All present know this, and yet few will even think about it, much less act on it. It is so much easier to go to sleep and forget all about it. And while New York is dully sleeping, if it were awake it would take cognizance of the great examples of productivity set by the continuous services of the Johns Hopkins and Ann Arbor Hospitals. Other places which have adopted the continuous service are Pennsylvania, Minneapolis, Iowa City, Cleveland, Galveston and St. Louis. In St. Louis a new hospital with $5,000,000 is assured and in addition to this a children's hospital is to be built, with one hundred and fifty beds. A new medical school on the highest lines will be developed there. Also the resignations of the whole faculty are in the hands of the authorities. And this state of affairs has only roused the East by striking terror into the hearts and homes of some of our medical colleges lest they lose their very best men for whom during so many years they have so illy provided. Let us get together then and make a life of scientific progress possible in a New York hospital. Do not think, however, that the mere promotion of a practitioner of medicine to a continuous service is going to transform him into an advanced medical thinker. Success depends upon the selection of the proper type of man who has had the proper training.

"Regarding appointment to the service of a great city hospital, there is room for much improvement. There should be a complete revolution in the present method. The right to inherit a position should be entirely eliminated as a factor. In general, the promotion of an assistant to the place of the master merely means the promotion into a prominent position of a younger man who more than likely owes his appointment not to his vigorous intellectuality, but rather to his submissive attitude during the days of his tutelage. This is a very widespread evil, this right to inherit. The cure for this is a greater migration of men among the medical institutions of this city and country. A man should not be cut off from a distinguished career in New York because his reputation has been founded in Syracuse or in New Haven. It seems that there must be a great strengthening all along the line if the rule were made that no assistant could ever succeed his chief. Then to rise, the assistant must through his capacity excite sufficient admiration to be called to take charge of a smaller institution. If he again succeeds he then might become eligible for a high position as one of the great masters of medicine in New York City. The scheme would do away with much that is scandalous regarding appointments to hospitals and medical schools in this country, and would inspire hospital trustees and givers to medical charity with a new confidence in the disinterestedness of medical men. This scheme is not utopian, or the mere dream of an idle extremist, but it is a part of the competitive system which has caused the rise of modern German medicine. By such a method you can help to vitalize scientific medicine. The man who rises to highest achievement in this country should be offered the highest reward in the shape of appointment to chairs in medical schools and places in hospitals in this great city. Were hospital trustees sure that such a procedure would be faithfully carried out, there would be no friction between them and their medical boards.

" With regard to the arrangement of a hospital for scientific research, the laboratory should be across the hall from the wards, or, at any rate, easy of access to the wards. In such laboratories great work is done in Germany. New hospitals should provide for such laboratories in order to attract the best men of the rising generation, some of whom have been thoroughly trained in the fundamental sciences of medicine, and have sufficient creative ability to have new ideas. With men of this class in charge of hospital wards, the laboratory becomes a hotbed for the development of young men along the highest lines. And the best young men will flock to such a standard wherever raised. There never was a more attractive opportunity than that afforded here in New York to do the right thing in the right way. And yet the years roll by and the old traditions stand protective of the old rotten system, blinding the eyes even of the honest and sincere and placing a deadening inertia over medical progress. And, finally, there must be some small endowment to pay for the brains concerned in such an establishment as this. The visiting physician should spend at least half his day in his wards and laboratory or with students of medicine, and failing this, should be retired. All others connected with his wards should spend their entire time in the service of the patients and the laboratories and the more experienced should be paid salaries. Here they can make a reputation for themselves. Here they can acquire fame at a time of life when new ideas come easily and rapidly. Here they can also be taught to curb their fancies properly. General adoption of any such plans as have been outlined must come slowly, if at all. They must ultimately be adopted either through intellectual appreciation of their value, or in imitation of a hospital like the new Rockefeller Hospital, which is to be established on these principles.

" One should not consider such a scheme as one of fanciful idealism. It is simply the substitution of work for fame in the place of work for gold during the early life of our best young men. The true ideal is yet higher.

> " 'And no one shall work for money,
> And no one shall work for fame,
> But each for the joy of the working.' "

# APPENDIX L

## "THE SURGEON'S POWER OF LIFE AND DEATH"

This article, to which repeated references have been made in the foregoing chapters, but which, unfortunately can only be produced in part, appeared in the *Independent Review* for December, 1906, and caused a rather rancorous discussion in the *Lancet*, and the *British Medical Journal*, which has not yet subsided. The author, Dr. James A. Rigby, who is Consulting Physician to the Preston and County of Lancaster Victoria Royal Infirmary and a reputable practitioner, has, of course, roused the ire of the "ethical" element of the profession—which in Great Britain means probably ninety-nine per cent.—yet he has bravely stuck to his guns and has succeeded in awakening much public interest in the abuses he has so fearlessly exposed.

"Gradually, progressively, almost imperceptibly, there has of recent years arisen in our midst a new tribunal, and one moreover of great power and far-reaching influence; this tribunal is endowed with the power of deciding questions of life and death, and as at present constituted there is no appeal whatever from its decisions, which are practically immutable and irresistible. Directly a man, after a more or less prolonged and more or less successful course of study and hospital experience, becomes capable of writing behind his name the letters M. B., M. D., M. R. C. S., F. R. C. S., L. R. C. P., or other cognate qualifications, he is at once given, in a vast number of cases, the power of deciding whether a person who has consulted him shall be submitted or not to an operation, the ultimate effect of which may cost him his life, or leave him seriously maimed or incapacitated for life. This terrible power of life and death is thus placed in the hands of an inexperienced youth, practically without any safeguard whatever; for, after the operation is over, provided the patient dies, the operator merely requires to fill up a form of certificate, furnished by the State, in which there is stated the disease for which the operation has been performed, the nature of the operation more or less explicitly expressed, with the fatal result. There is an end of the matter. No inquiry is instituted as to whether (1) the diagnosis on which the operation was founded was correct, which it is frequently not, (2) the patient was in a fit state to undergo the operation with an expectation of a favorable result, (3) the operation was skilfully performed by an experienced operator, (4) every precaution was taken by the operator to give his patient every possible chance of a successful result, (5) the patient as a result of the operation had a reasonable chance of being in a better position than he was before the operation if successful, i.e., whether as an individual he or she would be better fitted to carry on the functions of life in consequence of the operation having been performed.

"Nothing whatever is done by the State in the interest of the patient, everything is left to the *bona fides* and professional integrity of the operator, which it must be admitted is rarely abused, and the law, merely through the magic influence of the letters M. B., M. R. C. S., etc., etc., allows to remain uninvestigated a death which may have been caused by culpable ignorance, gross carelessness, want of adequate experience, or a host of other causes which require careful searching out and inquiring into. In this description there is nothing exaggerated, nothing overstated, but merely a plain unvarnished exposition of facts which may be verified any day in any part of the country and which it is now time should receive the careful and deliberate attention of the State. In the case of a naval officer losing his ship, even though no loss of life is involved, he is court-martialled and a searching investigation is instituted to decide whether or not he is in any way culpable or responsible for the loss of or the injury to his ship; again, when a military officer in command of men becomes involved in a disaster in which there is any loss of *personnel* or material, a more or less strict scrutiny is undertaken to prove that he has done what was humanly possible to avert or avoid the disaster; but in the case of the surgeon no such inquiry or investigation is made, and he may proceed on his happy-go-lucky way from one successful operation to another, secure in the consciousness that no inquiry into his conduct will be instituted, and that his professional conduct will not be in any way impugned,—unless, in a very exceptional case, a blunder so transparent is made that an inquiry of some sort is bound to follow, as, for instance, when a forgetful surgeon leaves in the abdominal cavity, after a laparotomy, a sponge or a pair of forceps or two; even then, it is doubtful if any inquiry would be made in most cases, unless some very vigilant relative or friend should happen to learn of the event, and strenuously insist on the facts being brought to light. In consequence of the advent of the use of anæsthetics, the development in the use of antiseptics, and the perfect cleanliness which has resulted from the discoveries and observations of Lord Lister, many operations in surgery which were formerly quite inadmissible are now performed with almost absolute security and with undoubted and permanent benefit to the patient; for these legitimate operations nothing but the greatest admiration and praise can be expressed and felt; but as in all other human affairs there is nothing good and useful that has not its fraudulent imitations, so in surgery there has arisen a class of surgeons, mostly young, often inexperienced in other safer and more rational methods of treatment, and above all quite callous and indifferent to the true welfare of their patients, whom they look upon merely in the light of subjects, to be experimented and operated upon. These surgeons, regardless of age or any other deterring considerations, have no hesitation in embittering the last moments of their patients by submitting them to what are practically hopeless operations, often under the specious plea of giving them a chance; thus, what should be a peaceful death-bed scene, becomes converted into a *séance* of operating surgeons, nurses *et hoc genus omne*, to whom the suffering patient is merely an interesting case. His obituary notice is another record in the case book of the operating surgeon, who, rightly from his point of view, has by constant repetition of such scenes, quite obliterated the acute sense of humanity he originally possessed.

" Thus in consequence of the change in the type of the individual reared, and also in consequence of the progress of surgery, the introduction of anæsthetics which render operations practically painless, and the adoption of antiseptic methods of treatment, which has rendered operations much safer, an enormous impetus has been given to operative surgery, so that it is quite safe to say that the number of operations in the last thirty years, even taking into consideration the increase of the population, has increased *pro rata* four-fold. This is as it should be; but now the time has come when the question of the personal responsibility of the operating surgeon should be considered seriously by the people at large. Operations may be divided into three classes: (1) legitimate and defensible, (2) illegitimate and indefensible, (3) those on the borderland between the two. We will now briefly consider these three classes.

" 1. Legitimate and defensible operations. Under this heading may be placed all those which give relief to pain, remove accessible growths, remove diseased, injured or useless members and organs—the scope of this article does not include surgical injuries. In fact, any operation may be described as legitimate and defensible which is undertaken for the benefit of the individual without unduly risking his life, so that at the conclusion of the operation the patient is placed in a better position than he was prior to the operation having been performed.

"2. Illegitimate and indefensible operations. In these the life of the patient is risked or shortened, and he or she is often put to vast pain, inconvenience and expense without any reasonable prospect of relief. It is notorious that many operations are performed as the result of a mistaken diagnosis, that cases of so-called appendicitis have been operated upon where the vermiform appendix has been found quite healthy, and that an operation for appendicitis has been recommended where the patient has declined to be operated upon, and subsequently made a perfect recovery without any operation whatever having been performed.

"An excellent example of an illegitimate and indefensible operation is the following: A blacksmith, aged about 35 years, was suffering from a cancer affecting the parietes of the abdomen just over the region of the liver. Considering the size and position of the growth my emphatic opinion was that the case was an irremediable one, and that under no circumstances whatever should any operative procedure be adopted. A few days after having expressed the above opinion, a note was sent to me by a well-known operating surgeon, saying that he had been consulted by the aforementioned blacksmith and that he had decided to remove the growth, also asking me to be present at the operation, which was fixed a few days later at the patient's own home. Prior to the operation being commenced it was my unpleasant duty to protest against its being undertaken on the grounds that it was absolutely useless, as the growth could not possibly be entirely removed, that most likely some of the internal organs would be found to be secondarily affected, and finally that the operation would imperil and shorten the man's life. Notwithstanding my protest the operation was proceeded with. It occupied close upon two hours, and was only very partially successful. It was found impossible to bring the margins of the resulting wound together. Strange to say, the patient did not die under the operation but lingered on in a state of great suffering for about three weeks. He was a member of the choir of a neighboring church, at which a subscription was raised to pay his doctor's bill, which was not a small one, but his wife and children were left in very penurious circumstances. No better example to my mind of a useless and improper operation could be given. To remove any possible misapprehension, it is advisable to state that the operator in that case has been dead for several years. To sum up, no operation should be undertaken unless there is a reasonable prospect of relief; unless the patient at the conclusion of the operation is likely to be left at least in as good a position as he was before. At the commencement of an operation the surgeon should remember that the thing cannot be undone, that for good or ill the operation is about to be performed, and he should, as far as is humanly possible, resolve that under no preventable circumstances shall his patient be in a worse position as a result of the operation than he was before.

"3. Operations that are on the borderland between defensible and indefensible. In many cases a patient may be suffering from such intense pain and misery as to make life insupportable and unendurable; in others the case may be very obscure; again, a case that is certainly fatal unless something is done, may offer as a last hope some remedial treatment by operation. Each of these classes requires different consideration. To take first the cases where an operation is performed in order to clear up obscurity. These are often so-called exploratory operations; these in my opinion should never be performed until every other method of perfecting the diagnosis has been exhausted. The surgeon or physician should train his hand and mind so accurately as to be able to determine what is going on inside by external examination which involves no risk; he should exercise patience, and if necessary ask for further advice, if he doubt his own competence, in preference to submitting his patient to risks which may prove fatal, and which in many cases are quite useless. In those cases that are likely to prove fatal unless some operative procedure is adopted, the possibility that he may be wrong in his diagnosis should be considered, and the question whether he is not deluding himself in saying that there is a chance, and so embittering the last moments of his patient, and adding to the already grievous trouble and anxiety the friends are suffering from without any firm hope of giving relief; in fine, he ought to let nature have a chance, that nature which often performs what seems almost miraculous. The most difficult problem to face is the one mentioned, where a case is admittedly hopeless but where the patient is suffering from such intolerable and unrelievable agony that it is felt that something must be done if possible; where not only is the patient himself suffering, but all his relatives and friends are tired out, and even where a staff of trained nurses is unequal to the task; the last resources of medicine and surgery are required to cope with these miserable and unfortunate cases.

" These cases are by no means rare or infrequent—cases in which there is constant and intolerable pain day and night, and where the strain of seeing the suffering is agonizing to the bystanders. Now in these cases is the surgeon to blame if, urged on to do it by the patient, urged on by the patient's friends, yea, urged on by his own humanity, he attempt some heroic operation which inwardly he knows has no chance of success, but which he also knows will in all probability relieve the patient not only of his sufferings but of life itself, and in which in fact the surgeon acts the part of the friendly executioner? That question is not for me to answer.

"Sufficient has now been said to answer my purpose, i.e., to found a basis on which to establish my thesis that the present position of operating surgery has founded what is in fact a new tribunal, and one, moreover, of great and far-reaching power with very little, if any, responsibility, and that in the interests of the people at large it is quite time this far-reaching power and lack of responsibility should be seriously inquired into, and that if it is found necessary its powers should be limited and its responsibility vastly increased by bringing each individual case operated upon, at any rate where a fatal termination ensues, under the notice and investigation of an authorized court of inquiry, either a new court of inquiry to be established for the purpose or some modification of the present Coroner's Court. In all other cases of death by violence or misadventure there is an inquiry made to determine if anybody be at fault, and there is no reason why in this particular instance such an inquiry should be evaded. As before stated, if a merchant captain or a naval captain lose his ship or have it seriously damaged either with or without loss of life, or if a military officer lose a position, stores or men, an inquiry or court-martial is at once instituted and the officer in charge has to clear himself of incompetence, ignorance, or want of due care in the discharge of his duties; and there is invariably an inquest on a person who dies under chloroform or any other anæsthetic. If so, there can be no reason why the operating surgeon in case of dire failure and loss of human life should not also be called upon to vindicate his conduct and capacity. If he were thus liable to be called upon he would be stimulated by a grave sense of responsibility not to enter upon or undertake any such operation in a flippant, uncertain manner, knowing that if he did so he would be required to furnish unimpeachable and incontrovertible reasons for having so undertaken it, and subjected his patients to perils of such consideration and moment as to involve the possible loss of their life."

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